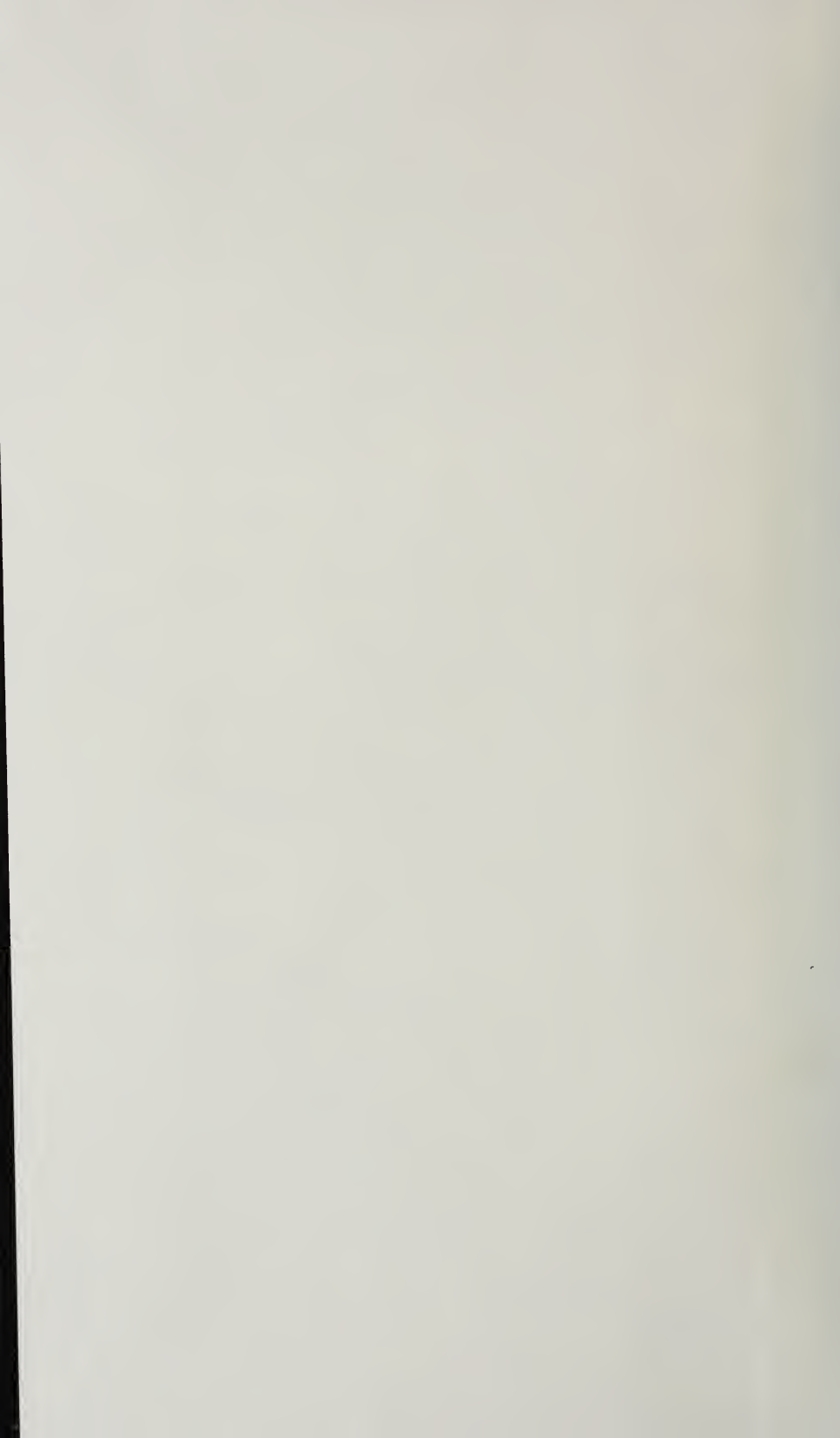


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CATASTROPHIC ILLNESS EXPENSES

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

ON

EXPANDING MEDICARE TO INCLUDE CATASTROPHIC COVERAGE

JANUARY 29; MARCH 3, 4, 10, AND 30, 1987

Serial 100-7

Printed for the use of the Committee on Ways and Means





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CATASTROPHIC ILLNESS EXPENSES

THURSDAY, JANUARY 29, 1987

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The full committee and subcommittee met, pursuant to call, at 9:30 a.m., in room 1100, Longworth House Office Building, Hon. Fortney H. (Pete) Stark (chairman of the Subcommittee on Health) presiding.

[Press releases announcing the hearings follow:]

(1)

FOR IMMEDIATE RELEASE
THURSDAY, JANUARY 15, 1987

PRESS RELEASE #2
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-3625

THE HONORABLE FORTNEY H. (PETE) STARK (D., CALIF.),
CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS,
U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING BEFORE THE
FULL COMMITTEE ON WAYS AND MEANS AND THE SUBCOMMITTEE ON HEALTH
IN ORDER TO RECEIVE TESTIMONY FROM SECRETARY OTIS R. BOWEN
ON CATASTROPHIC ILLNESS EXPENSES

The Honorable Fortney H. (Pete) Stark (D., Calif.), Chairman of the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, today announced that a hearing will be held before the full Committee on Ways and Means and its Subcommittee on Health to receive testimony from the Honorable Otis R. Bowen, M.D., Secretary of the Department of Health and Human Services, on the Department's Report to President Reagan on Catastrophic Illness Expenses. The hearing will be held on Thursday, January 29, 1987, in the Committee's main hearing room, 1100 Longworth House Office Building, beginning at 9:30 a.m.

BACKGROUND

The medicare program has coverage gaps that leave the elderly with acute-care needs vulnerable to catastrophic out-of-pocket expenses. In 1986, 22 percent of the elderly had to spend 15 percent, or more, of their incomes on medical care, and another 21 percent spent 10 to 15 percent of their incomes for medical care. Given that nearly half of medicare beneficiaries have incomes under \$10,000, out-of-pocket expenses for medical care can prove to be a true financial catastrophe. Even though the medicare program in 1986 spent over \$70 billion on health care, the elderly also had out-of-pocket medical expenses of \$30 billion, not including long-term care.

Thirty-seven million Americans, according to the latest Census Bureau figures, are without health insurance at some time during the year. An estimated nine million persons under age 65 have inadequate health insurance. Contrary to the stereotype that the uninsured are unemployed and living in poverty, approximately two-thirds of the uninsured are the employees, and their dependents, of employers who do not provide health insurance. With or without health insurance, a significant percentage of the nonelderly face catastrophic medical costs. While 1.9 percent of those without insurance spend more than \$20,000 a year, 2.3 percent of those with private insurance, and seven percent of those covered under medicaid, were forced to spend more than \$20,000 a year on medical expenses.

Secretary Bowen has been invited to testify on the HHS report to the President concerning these and related issues. Additional hearings will be scheduled at a later date at which public witnesses will be given the opportunity to testify on issues and proposals pertaining to catastrophic illness expenses. These hearings will be announced in a subsequent press release.

FOR IMMEDIATE RELEASE
THURSDAY, FEBRUARY 12, 1987

PR #2
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1114 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY H. (PETE) STARK (D., CALIF.),
CHAIRMAN, SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES
ANNOUNCES HEARINGS ON EXPANDING MEDICARE TO INCLUDE
CATASTROPHIC COVERAGE

The Honorable Fortney H. (Pete) Stark (D., Calif.),
Chairman, Subcommittee on Health, Committee on Ways and Means,
U. S. House of Representatives, announced today that the
Subcommittee will conduct two days of hearings on providing
catastrophic coverage in the Medicare program.

The hearings will be held on Wednesday, March 4, and
Tuesday, March 10, 1987. The March 4 hearing will be held in
room B-318 Rayburn House Office Building, beginning at
9:30 a.m. The March 10 hearing will be held in room 1100
Longworth House Office Building, beginning at 10:00 a.m.

The hearings will focus on catastrophic benefits in
Medicare such as: 1) protection against multiple and lengthy
hospital stays; 2) improving benefits for skilled nursing
facility care; and 3) restricting out-of-pocket costs for Part B
covered services each year. The hearings will also focus on
ways to finance the benefits such as: 1) taxing the actuarial
value of the subsidized portion of Parts A and B of Medicare;
2) increasing the Part B premium, with special consideration for
low income beneficiaries; and 3) other options witnesses may
raise.

Because of time limitations, testimony will be limited to
invited witnesses. For the March 4 hearing, the witnesses will
include: Robert Ball, former Commissioner of the Social
Security Administration; Robert Myers, former Chief Actuary of
the Social Security Administration; American Association of
Retired Persons; National Council of Senior Citizens, and
Villers Advocacy Associates. For the March 10 hearing, the
witnesses will include: General Accounting Office; Consumers
Union; Health Insurance Association of America; Blue Cross/Blue
Shield; American Hospital Association; American Medical
Association; AFL-CIO; Washington Business Group on Health, and
U.S. Chamber of Commerce.

WRITTEN STATEMENTS FOR THE RECORD OF THE HEARING:

Persons wishing to submit a written statement for the
printed record of these hearings should submit at least six (6)
copies of their statements by the close of business, Monday,
March 31, 1987, to Joseph K. Dowley, Chief Counsel, Committee
on Ways and Means, U.S. House of Representatives, 1102
Longworth House Office Building, Washington D.C. 20515. If
those filing written statements for the record of the printed
hearing wish to have their statements distributed to the press
and interested public, they may deliver 75 additional copies
for this purpose to 1114 Longworth House Office Building on the
date prior to the hearing.

SEE ENCLOSED FORMATTING REQUIREMENTS

FOR IMMEDIATE RELEASE
FRIDAY, FEBRUARY 27, 1987

PRESS RELEASE #5
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY H. (PETE) STARK (D., CALIF.)
CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING AT WHICH
MEMBERS WILL PRESENT THEIR VIEWS
ON MEDICARE CATASTROPHIC PROPOSALS

The Honorable Fortney H. (Pete) Stark (D. Calif.),
Chairman of the Subcommittee on Health, Committee on Ways and
Means, U.S. House of Representatives, today announced that the
Subcommittee on Health will hold a hearing to receive testimony
from Members on including catastrophic coverage in the Medicare
program.

The hearing will begin at 9:30 a.m., on Tuesday,
March 3, 1987, in room B-318 Rayburn House Office Building.

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**** NOTICE -- CHANGE IN LOCATION ****

FOR IMMEDIATE RELEASE
THURSDAY, MARCH 5, 1987

PRESS RELEASE #6
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
1114 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY H. (PETE) STARK (D., CALIF.),
CHAIRMAN, SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES
ANNOUNCES A CHANGE IN LOCATION FOR THE HEARING ON
CATASTROPHIC COVERAGE UNDER MEDICARE
MARCH 10, 1987

The Honorable Fortney H. (Pete) Stark (D., Calif.),
Chairman of the Subcommittee on Health, Committee on Ways and
Means, U.S. House of Representatives, today announced a change
in the location for the hearing on March 10, 1987, regarding
catastrophic coverage under the Medicare program. The hearing
will be held in room H-137 Capitol Building from 10:00 a.m. to
12:00 p.m. The hearing will then resume in room 1100 Longworth
House Office Building at 1:00 p.m.

All other details for the hearing remain the same. (See
Subcommittee press release #2, dated February 12, 1987.)

FOR IMMEDIATE RELEASE
MONDAY, MARCH 23, 1987

PRESS RELEASE #7
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1114 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY H. (PETE) STARK (D., CALIF.),
CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS,
U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON
EXPANDING MEDICARE TO INCLUDE CATASTROPHIC COVERAGE
TO BE HELD ON MONDAY, MARCH 30, 1987

The Honorable Fortney H. (Pete) Stark (D., Calif.),
Chairman, Subcommittee on Health, Committee on Ways and Means,
U. S. House of Representatives, announced today that the
Subcommittee will conduct a final hearing on providing
catastrophic coverage under the Medicare program. The hearing
will be held on Monday, March 30, 1987, beginning at
10:00 a.m., in room 1100 Longworth House Office Building.

In announcing the hearing, Chairman Stark said, "Limiting
out-of-pocket expenses for medical care for our nation's
elderly must be a priority of the Subcommittee. Determining
what benefits should be included under the limits, what these
limits should be, and how to finance them are the issues the
Subcommittee needs to address."

Administration officials will review the technical details
of H.R. 1280 and H.R. 1281 and other legislative proposals to
expand Medicare benefits to provide catastrophic coverage.

Additional witnesses will focus on issues relating to the
expansion of Medicare benefits including both an outpatient
prescription drug benefit and improved mental health benefits.
The hearing will also review State regulation of medical
supplemental insurance (Medigap) policies the elderly now
purchase to help limit their medical expenses. The
Administration, the National Association of Insurance
Commissioners, and other invited witnesses will present
testimony at this hearing.

Oral testimony will be heard from invited witnesses only.
However, any individual or organization may submit a written
statement for consideration by the Subcommittee and for
inclusion in the printed record of the hearing.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:

For those who wish to file a written statement for the
printed record of the hearing, six (6) copies are required and
must be submitted by the close of business on Tuesday,
April 21, 1987, to Joseph K. Dowley, Chief Counsel, Committee
on Ways and Means, U.S. House of Representatives, 1102
Longworth House Office Building, Washington, D.C. 20515. An
additional supply of statements for the printed record may be
furnished for distribution to the press and public if supplied
to the Subcommittee office, 1114 Longworth House Office
Building, before the hearing begins.

SEE ENCLOSED FORMATTING REQUIREMENTS

Chairman STARK. The committee will come to order.

This is a meeting of the Committee on Ways and Means jointly with the Subcommittee on Health.

We are honored to have Secretary Bowen of the U.S. Department of Health and Human Services here with us this morning to discuss the problem of the cost of catastrophic illness and proposals to protect the older Americans from that catastrophe.

I will soon introduce Congressman Duncan, Congressman Daub, and other members of the full committee and subcommittee who have statements on this area.

The proposal that we are developing within the subcommittee will include provisions that will protect against the high costs of multiple and lengthy hospital stays. It will improve benefits for skilled nursing facility care, hopefully by reducing the coinsurance amounts, and attempt to limit overall out-of-pocket costs for both part B and part A.

We are also hoping to finance this improved package in a revenue-neutral fashion, and in as progressive a manner as we are able. This legislation is the subcommittee's top priority, and I guess we will throw down the gauntlet and say, "President, ready or not, we intend to move on this problem, and we think we have broad support from the American public."

We are very interested in Secretary Bowen's plans for dealing with the 37 million working age and young Americans who are without any health insurance. Our witness today is a family physician and a former Governor who knows firsthand the price of catastrophic illness, both on a personal level and in the overall cost to society.

I further state that he is a man who understands full well the political complications and implications of every facet of his proposal, our proposal, and any one that may result as a compromise.

The 1982 Social Security Advisory Committee raised the issue to better fund it, and since that time he has spent countless hours educating all of us on the need and the complexities of accomplishing this goal.

Accompanying Secretary Bowen is Tom Burke, his chief of staff, who has also worked tirelessly on this issue; and Ron Docksai, the Department's Assistant Secretary for Legislation.

I would like to welcome both of you gentlemen.

I would now like to recognize other members of the committee who have opening comments.

[The opening statement of Chairman Stark follows. By subsequent unanimous consent, the opening statements of Congressmen Ford and Matsui were ordered printed.]

OPENING STATEMENT OF CHAIRMAN FORTNEY H. (PETE) STARK

President Reagan, in his State of the Union Speech Tuesday night, said, "Let us remove a financial specter facing our older Americans—fear of an illness so expensive that it can result in having to make an intolerable choice between bankruptcy and death. I will submit legislation shortly to help free the elderly from the fear of catastrophic illness."

The time is right for action. The need for catastrophic coverage for older Americans is long overdue.

Each year hundreds of thousands of senior citizens who spend long periods in the hospital find that their Medicare coverage has run out. To their utter dismay and

worse, to their financial ruin, the elderly find themselves responsible for bills of thousands, or in some cases hundreds of thousands of dollars.

For these low and moderate income elderly the costs of catastrophic illness can quickly gobble up lifetime savings, leaving huge debts to boot. In 1986, over 20 percent of senior citizens had to spend at least 15 percent of their income on their medical care, while 7 percent were forced to spend a whopping 25 percent or more of their income paying medical bills.

Even though Social Security payments have lifted many of the elderly out of poverty, 19 percent or about 6 million, have incomes below the poverty threshold of \$5,000, and 49 percent of older Americans still have incomes under \$10,000. Needless to say, paying 25 percent of a \$10,000 income on medical care is truly catastrophic.

The fear of bankruptcy from a catastrophic illness has driven 70 percent of seniors to buy often questionable Medigap policies—policies that pay on average only sixty cents on the dollar in benefits—policies that don't cover pre-existing conditions or age relate their premiums.

Medicare can do much better. With only 2 percent administrative costs, Medicare can pay out 98 percent in benefits without denying benefits for those with pre-existing conditions or charging higher premiums to our oldest of senior citizens.

Worse off are the five million elderly who can't afford to buy Medigap policies but aren't poor enough to qualify for medicaid. For these older Americans, who statistically are the oldest, and who are the poorest in income and health, Medicare can prove a cruel and empty promise.

Secretary Bowen, I am pleased to hear your proposals to meet the catastrophic coverage needs of our Nation's older Americans.

I am equally interested to hear your plans on how to deal with the 37 million Americans who are without health insurance. As you know, approximately two-thirds of the uninsured are the employees, and their dependents, of employers who do not provide health insurance.

With or without health insurance, too many of the nonelderly face catastrophic medical costs. We must find ways to provide access to catastrophic health insurance for younger Americans and especially our Nation's children.

I will soon be introducing with Congressman Gradison legislation on catastrophic coverage for the Medicare population.

The proposal we are developing will include provisions such as:

Protection for multiple and lengthy hospital stays;

Improved benefits for skilled nursing facility care by reducing coinsurance amounts; and

Limiting out-of-pocket costs for Part B covered services each year.

We intend to finance this benefit improvement package in a progressive and revenue neutral fashion.

This legislation will be the Subcommittee's top priority.

I will also be introducing legislation to address the catastrophic medical needs of all Americans without such protection. I hope that my colleagues on the Ways and Means Committee will join with me in moving these proposals forward.

The need for catastrophic medical care legislation is not and should not be a partisan issue. Mr. Secretary and Members of this Committee, we have much to do together, and I hope that we will see the passage of legislation to end the grim spector of financial ruin caused by a catastrophic illness.

Our witness today is a family physician and former Governor who knows first hand the price of catastrophic illness both on a personal level and on a social scale. As Chairman of the 1982 Social Security Advisory Committee he raised the issue of the need to better fund older Americans' catastrophic illness expenses under Medicare. He has since spent countless hours educating us all on the need for legislation in this area. I commend him for his leadership role and hope that we will all be satisfied by the final product of our labors.

With Secretary Bowen is Tom Burke, Chief of Staff, who has also worked tirelessly on this issue.

CONGRESSMAN HAROLD FORD: OPENING REMARKS BEFORE WAYS & MEANS
SUBCOMMITTEE ON HEALTH HEARING ON CATASTROPHIC ILLNESS EXPENSES
JANUARY 29, 1987 1100 LONGWORTH HOB

I WAS VERY PLEASED TUESDAY EVENING TO HEAR THE PRESIDENT TURN HIS ATTENTION TO TWO SIGNIFICANTLY RELATED PROBLEMS FACING OUR NATION: CATASTROPHIC HEALTH CARE COSTS AND WELFARE REFORM. ALTHOUGH WE ARE HERE TODAY TO CONSIDER THE OPPRESSIVE COST OF CATASTROPHIC HEALTH CARE WE WOULD BE REMISS IF THE RELATIONSHIP OF CATASTROPHIC HEALTH CARE COSTS TO POVERTY WAS OVERLOOKED.

AN ACUTE OR LONG-TERM CATASTROPHIC ILLNESS CAN THRUST SOLIDLY MIDDLE-CLASS, NOT TO MENTION THE MARGINALLY POOR, INTO FINANCIAL RUIN. THE IMPACT OF CATASTROPHIC ILLNESS IS FELT BY BOTH THE UNINSURED AS WELL AS THE INSURED. SUCH ILLNESSES ARE BEYOND OUR CONTROL AND THREATEN THE PHYSICAL AND FINANCIAL WELLBEINGS OF OUR FAMILIES AND OURSELVES. WHEN THE IMPACT OF CATASTROPHIC ILLNESS ON SPECIFIC GROUPS SUCH AS THE ELDERLY IS CONSIDERED THE RELATIONSHIP BETWEEN CATASTROPHIC CARE COSTS AND POVERTY BECOMES EVEN MORE STARTLING.

HAVING REVIEWED SECRETARY BOWEN'S PROPOSALS FOR CATASTROPHIC HEALTH CARE I LOOK FORWARD TO THIS OPPORTUNITY TO CONSIDER ITS PARTICULARS. I THINK IT OFFERS THIS CONGRESS IMPORTANT DISCUSSION POINTS WHICH CAN FORM THE BASIS FOR COMPREHENSIVE LEGISLATION TO PROVIDE ACCESS TO HIGH QUALITY CATASTROPHIC HEALTH CARE COVERAGE THAT WILL NOT REQUIRE AMERICANS TO BECOME IMPOVERISHED.

MUCH OF THE DEBATE ABOUT CATASTROPHIC CARE IS CENTERED AROUND THE METHOD AND SOURCE OF ITS FINANCING. I HOPE THAT AS WE DEBATE AND DRAFT LEGISLATION WE AVOID EXTREMES OF PUBLIC FINANCING VERSUS PRIVATE FINANCING, OR FEDERAL FINANCING VERSUS STATE FINANCING. WE MUST DEVISE A COMBINATION OF PUBLIC AND PRIVATE SECTOR FINANCING WHICH WILL DISTRIBUTE ADMINISTRATIVE AND FINANCIAL RESPONSIBILITIES BETWEEN THE FEDERAL AND STATE GOVERNMENTS AS WELL AS PRIVATE INSURERS.

LET US NOT PUT APPEARANCE BEFORE REALITY BY PROPOSING A GRAND PRIVATIZATION OF CATASTROPHIC HEALTH CARE WHICH IS TOO CONFUSING AND QUESTIONABLE TO BE OF REAL VALUE. WE WILL NEED THE COURAGE TO QUESTION WHETHER A TRULY BUDGET NEUTRAL CATASTROPHIC HEALTH CARE PROGRAM IS INDEED POSSIBLE.

AS WE PONDER THESE QUESTIONS IT IS IMPORTANT THAT THE CONGRESS, THE PRESIDENT, AND THE NATION PARTICIPATE IN FULL COOPERATION SO THAT WE CREATE A CATASTROPHIC HEALTH CARE SYSTEM WHICH MEETS THE VARIETY OF ECONOMIC NEEDS THAT CATASTROPHIC HEALTH CARE BENEFICIARIES HAVE.

CONGRESSMAN ROBERT T. MATSUI

Opening Statement
Before
The Committee on Ways and Means

January 29, 1987

CATASTROPHIC ILLNESS EXPENSES

Mr. Chairman, I know all of us agree that no American ought to face financial ruin because of the necessity of medical care. But beyond that assertion, there is very little consensus about how to accomplish this task. In fact, there is often little agreement on what constitutes a catastrophic medical cost.

While there appears to be agreement on the need to protect our elderly, the next major step is to clarify and define the concept of catastrophic coverage. It means many different things to many different people: if we were to ask the President, Secretary Bowen, our fellow Colleagues, a disabled individual, a retiree, a worker, an older women living alone, or a person caring for an acutely or chronically ill relative, we would hear a variety of definitions.

Furthermore, the definition of catastrophic coverage would apply very differently to the needs of the under 65, non-disabled population, versus our elderly, disabled population. To base a plan on acute care only and call it "catastrophic insurance for the elderly" would be highly deceptive. Such a plan would only help to pay limited expenses for a very few aged in need while failing to meet the catastrophic costs for the majority.

Approximately 1 in 4 of the 28 million Medicare beneficiaries are hospitalized each year. Less than 200,000 remain hospitalized beyond 60 days and an even fewer amount are hospitalized beyond 90 days.

Hospital related expenses can be devastating to Medicare beneficiaries. However, the majority of older people need catastrophic insurance not to insure against the cost of a long hospital stay, but against the uncovered expenses of nursing home care, community-based services, and chronic illnesses requiring long-term care.

The sad fact is that, because of skyrocketing health care costs and the absence of truly comprehensive insurance coverage, the elderly today spend the same proportion of their incomes on health care as was the case before Medicare and Medicaid were established.

In 1984, average out-of-pocket health care costs for the elderly accounted for 15% of their income, the same level that existed before medicare was enacted. Not including nursing home and other long-term care, the average annual out-of-pocket health expenses for the elderly reached \$1,055 in 1984---more than three times the average amount (\$310) spent by other americans. Including nursing home costs, the average out-of-pocket health expenses of the elderly reached \$1.705 per year.

Three aspects of the Medicare and Medicaid programs that are not widely understood account for most of the extremely high out-of-pocket costs borne by many of the low-income elderly.

First, Medicare fails to cover many vital health care needs, such as physical examinations, out-of-hospital prescription drugs, eyeglasses, hearing aids, dentures, and chronic long-term care.

Second, the elderly must normally pay premiums, coinsurance charges, and deductibles for those services that Medicare does cover. These costs have soared. The deductible for hospital care has increased by 155% in just the past six years, from \$204 in 1981 to \$520 in 1987--an increase 5 times as great as the overall rate of inflation. The annual Medicare premium for physician services has increased by 86.5% in six years, from \$115.20 in 1981 to \$214.890 for 1987. Moreover, even after the deductible has been paid, Medicare normally pays only 80% of all reasonable charges billed, contributing significantly to the out-of-pocket health costs encountered by the typical elderly.

The third problem involves Medicaid. The Medicaid program is routinely described as "health insurance for the poor". In practice however, Medicaid is unavailable to the overwhelmingly majority of the elderly poor. Only 36% of the non-institutionalized elderly poor were enrolled in Medicaid in 1984. In other words, nearly 2 out of 3 elderly poor not in nursing homes have no Medicaid coverage at all and must bear, directly or indirectly the full cost of Medicare cost-sharing and uncovered services.

Any insurance plan that purports to be catastrophic must be congruent with the elderly population's true need. If a plan is not congruent, it will neither be worth pursuing as federal policy nor worth buying with public or private funds.

I congratulate Secretary Bowen for his year long effort in designing a catastrophic health care insurance plan. However, I am disappointed that this plan is not more comprehensive in scope and is targeted to only our elderly population. I caution my colleagues to be careful in endorsing a limited proposal and defining it as catastrophic coverage. I believe the proposal is a step in the right direction, but it is a far way off from actually addressing the catastrophic health insurance needs of our population. President Reagan has promised us his legislative response to address catastrophic health costs and I anxiously await its unveiling. While I hope that it will be a more comprehensive approach, I fear that it too may be limited in scope and may signal a retreat from the federal government's attempt to address this issue.

The urgency to ease the pressure of catastrophic expenses should not remain unanswered. Clearly the number of the aged and the population at risk is continuing to mount. Today's and tomorrow's aged and their families must be protected against the cost of catastrophic costs. I look forward to working with my colleagues toward assuring this protection.

Chairman STARK. Mr. Duncan.

Mr. DUNCAN. Thank you, Mr. Chairman.

I have no written statement, but I would like to compliment you, Dr. Bowen, on your initiative in this great problem that faces us in this country, and that is catastrophic illness, which I think has touched almost every family in this country.

I have been on the committee about 16 years, but it is the first time I think we have had a Secretary that really brought us something, that we can use as a starting point for catastrophic health insurance. You have taken the initial step. I hope, that we can work out something acceptable on a bipartisan basis and not end up with some big document that we can't afford, or perhaps don't need.

But I feel this year something is really going to happen in this field, and I give you credit for getting the ball started. Thank you so much.

Chairman STARK. Mr. Daub.

Mr. DAUB. Mr. Chairman, I want first to thank you for starting this process. I don't think we should minimize that. Because this committee is the place where these seeds which have been planted, and where they can be nurtured and "growed," as my ranking member, Mr. Duncan, said, on a bipartisan basis, it is very important to recognize your interest in being so quick out of the gate. And with my compliments, your leadership in that regard is very much appreciated.

I do want to offer a few brief remarks at this first in a series of Ways and Means hearings on what we are now calling the issue of catastrophic health insurance. Secretary Bowen, I really want to commend the time and effort you have devoted to this issue. While the idea of expanding Medicare to cover catastrophic illness has been kicked around for several years, it has been your continued commitment to this issue that has brought us here today to begin the process of developing legislation.

I do believe, however, that we are closer to the starting point than to the end of our work on designing a catastrophic bill. I am very concerned, actually, that we may be misleading our elderly constituents with all this talk of "catastrophic coverage." I put that in quotes.

In your final report to the President on this issue, Mr. Secretary, you highlight the fact that many individuals are unaware of the degree to which they are financially at risk for certain medical costs. The insurance industry has also indicated to me that a primary reason for the lack of beneficiary interest in long-term care or nursing home policies is this same level of misconception about what costs Medicare does cover.

It seems, then, dangerous to me to promise my constituents that your report will take care of all of their catastrophic health care needs. The definition of "catastrophic illness," in quotes, alone can be interpreted differently by each of us, depending upon where we see the greatest demand for need. My concern lies primarily in the area of long-term care, whether it be community-based or nursing home care. And I hope that we will not miss the opportunity to address these critical and real needs of our elderly.

Finally, Mr. Chairman and Secretary Bowen, I worry that this focus upon enacting only an acute care catastrophic mechanism is going to have a detrimental impact on our private insurance market. If things proceed in one direction alone, not only will we be taking away from the private sector's current work with medigap policies, but we may be taking away what little incentive the private sector does have to beef up its work on long-term care policies.

Again, I believe we have an excellent opportunity to address some very critical health care policy issues, but hope that we do so in a manner which looks forward to tomorrow as well as takes care of the needs that we have today.

Mr. Chairman, thank you.

Again, Mr. Secretary, we are anxious to hear your testimony and delighted to be working with you on this most important initiative. Secretary BOWEN. Thank you.

Chairman STARK. Any other statements?

Mr. BROWN. Mr. Chairman?

Chairman STARK. Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. Secretary, we are anxious to hear your words. I won't delay that. But one concern I have heard often expressed is that the Government may be in the process of suggesting some coverage that involves a shift of resources away from our young people and away from other sectors of the economy merely to keep terminally ill patients alive for an extended period of time through artificial mechanisms.

Clearly, we hope that that is not the focus of your thrust, and we will look forward to seeing how you handle the questions of diversion of vast resources to those that are terminally and irretrievably ill, and whether or not there is a way to deal with that very delicate question other than simply the humanitarian effort that I know you are concerned about.

I yield back the balance of my time.

Mr. PICKLE. Mr. Chairman, I don't have a statement. I am just anxious to hear what Secretary Bowen has to recommend and whether there is an agreement between you and the administration on what to recommend. So I would hope that you could proceed as soon as possible.

Chairman STARK. Mr. Moody.

Mr. MOODY. Just briefly, Mr. Chairman, I certainly want to commend Secretary Bowen for reopening the debate on a vital public issue. We know there have been 8 million more people in our population that have become 65 or older from the 1970 through the 1980 period. We know the average cost of nursing home care is about \$22,000 a year.

I have one more question I hope you will address this morning. I hope any plan we adopt will be generationally neutral. It should not, on top of the FICA, put on top of one generation to support another with far lower prospects to support themselves when they come along to be supported because of the demographic changes; that we will not on top of that impose heavy burdens on the working generation to support the older generation.

I hope we will be looking for ways to handle this important need that are generationally more neutral than I think the social security system is at this time.

Thank you.

Chairman STARK. Mr. Secretary, if there are no further members who wish to welcome you, we all join and anxiously await your comments. Would you proceed in any manner you care to.

STATEMENT OF HON. OTIS R. BOWEN, M.D., SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY THOMAS R. BURKE, CHIEF OF STAFF; AND RONALD F. DOCKSAI, ASSISTANT SECRETARY FOR LEGISLATION

Secretary BOWEN. Thank you very much, Chairman Stark and members of the House Committee on Ways and Means, and your Subcommittee on Health. I am honored by this opportunity to testify on the issue which has been at the top of my agenda: that is, protecting our elderly against the devastating effects of catastrophic health care costs.

The subject for today's hearing is one which I know is of the utmost mutual concern. I commend Chairman Rostenkowski for holding today's hearing. Many of you—Chairman Stark, Representative Duncan, and Representative Gradison, among others—have shown great leadership in developing health policy.

I am hopeful this hearing will mark the onset of our open dialogue on this important health issue, as we work together to find the appropriate private and public sector solutions to a pressing problem.

THE OPTIONS

Be it through our personal experiences, or those of family or friends, we certainly have all seen how a devastating illness can destroy the financial security of a family.

President Reagan deserves the thanks of all Americans for recognizing this need. He has been a long-time supporter of catastrophic coverage—first as Governor of California, and now as President. Without his leadership, I doubt that we would be having these discussions.

That is why the President asked me last February to report options to him on how the private sector and Government can work together to address the problems of affordable insurance for those whose life savings would otherwise be threatened when a catastrophic illness strikes.

My report provides a good starting point to begin the debate of how to address the various problems associated with catastrophic health care coverage.

In conducting the study, at the outset we recognized that the catastrophic illness problem is both large and complex. The possible solutions to this problem are numerous—and there is no single policy that will reduce the catastrophic burden for everyone.

Let me highlight what we have been doing in the year since the President asked for a study of this issue.

Many people and organizations contributed to our work. One prong of our efforts was a Private/Public Sector Advisory Commit-

tee I established to actively solicit information from all interested parties throughout the country on their concerns and their ideas to solve the catastrophic health problem.

This committee was chaired by Jim Balog, vice chairman of Drexel-Burnham-Lambert, a major New York investment brokerage firm. We selected a blue-ribbon panel representing a broad spectrum of the American public, including representatives for senior citizens, physicians, insurers, business, and elected officials from all levels of government.

The committee held eight public forums and heard from over 100 organizations and individuals. Last August, the Private/Public Sector Advisory Committee's efforts culminated in its report to me, synthesizing these numerous points of view.

In addition to the committee's work, the other prong of our efforts was a detailed technical analysis of policy options for catastrophic illness. Department staff consulted technical experts from all over the country to ensure that no major option and no major argument was omitted. All told, over 50 options were analyzed in three technical groups covering 1,600 pages.

There are far too many policy options that were considered to allow full discussion here. However, these are discussed in detail in the copy of the report which was provided to you shortly after it was sent to the President.

THE ELDERLY FACING ACUTE EXPENSES

To understand the catastrophic illness problem, three groups of people must be considered: one, the elderly facing acute care expenses; two, the elderly facing long-term care expenses; and three, the general population under the age of 65.

The chance that a catastrophic illness event will strike a member of these different groups occurs at different rates and frequencies.

Elderly Americans require more medical care than younger persons, and are more apt to suffer the consequences of an acute illness or need long-term care.

Of the more than 30 million elderly and disabled Medicare beneficiaries, approximately 1.2 million will incur personal costs for acute care of \$2,000 or more in 1987. This can be a heavy burden for those elderly living on \$6,000 to \$7,000 in social security benefits.

Virtually all elderly have acute care insurance protection under Medicare. Nearly two-thirds also have private supplementary insurance, or medigap. But there still may be significant gaps in coverage.

As you are aware, Medicare hospital coverage is limited; after 60 days, a Medicare patient begins to make increasingly costly payments. There is also a required 20 percent copayment for all physician services covered by Medicare.

Medigap insurance helps for the 65 percent of the elderly who buy it. But even with medigap, an individual may face significant out-of-pocket costs. The State-operated Medicaid program may also help with about 13 percent of the elderly, but there are limits on the kinds of services provided.

To improve catastrophic protection for the elderly and disabled facing acute care expenses, my report suggested three options: that Medicare be restructured to provide catastrophic protection financed by an actuarially sound additional premium of \$4.92 per month; that Medicare be restructured to provide for catastrophic protection with increased cost-sharing related to income; and third, that Medicare be restructured to include catastrophic coverage with increased cost-sharing unrelated to income.

THE ELDERLY AND LONG-TERM CARE

Long-term care ranges from informal, unpaid care provided by family and friends to full nursing home care. It is not typically associated with specific diagnoses, but rather the need for assistance in activities necessary for daily living.

There is limited private insurance coverage for long-term care, and the only major Federal program that covers such care is Medicaid—of which eligibility is restricted to low-income or medically indigent patients.

Most long-term care is provided free of charge by relatives and friends. The strong family and community support for the elderly is one of the finest aspects of American life.

But, in addition, 1.4 million elderly currently receive care in nursing homes every day. The expense averages \$22,000 a year. These expenses are not covered by Medicare, nor are they usually covered by private insurance. Unfortunately, many seniors believe that nursing home expenses are covered by Medicare or Medigap. The truth often comes as a shock. And these individuals find all their savings consumed by a stay in a nursing home.

The urgency of long-term care as a policy problem is increasing as the population ages. Within the next 45 years, the number of people living to age 85 and beyond will quadruple. By the year 2030, 8.6 million Americans will be over the age of 85, compared with 2.7 million in 1985. These are the people in need of long-term care, and these are the people who should begin now—in their middle age—to make provisions for that care.

Obviously, we need to look far down the road for any approach to long-term care. Changes in the system would be very costly, and won't come overnight. Among the report's many options, two approaches, which were developed prior to tax reform, would have:

No. 1, encouraged personal savings for long-term care expenses. One idea we had before enactment of the Tax Reform Act was to consider tax incentives, such as individual medical accounts. This could be coupled with insurance and be an effective method, not only for coverage, but also for prevention of thousands of Medicaid enrollments.

No. 2, encouraged the development of private long-term care insurance. There is clearly a need for more innovative and affordable policies of this type. Again, before enactment of the tax bill, we had considered some approaches using the Tax Code. The President's tax reform initiative eliminated many of the Tax Code's incentive features that narrowed the tax base, substituting lower tax rates for our citizens. With the enactment of tax reform, there are other options being considered that would not narrow the tax base.

One action about which there is widespread agreement is to educate the public about the costs of long-term care and the lack of coverage for those costs under Medicare and Medigap insurance.

The Federal Government can work with private industry and other levels of government to help people understand what is not covered under existing insurance, and to encourage them to make provisions for their future needs.

THE GENERAL POPULATION

Finally, I would like to mention catastrophic protection for those people under the age of 65. The majority of non-elderly persons have private insurance coverage, most of which is employment-related, and much of which provides solid protection against catastrophic expenses.

A significant amount is also provided by Medicare for those disabled; Medicaid for low-income families with dependent children; and other Government insurance for members of the Armed Forces.

It has been estimated that some 30 million people under the age of 65 have no health insurance at all, and 10 million have inadequate coverage for catastrophically high expenses. About three-quarters of the uninsured live in families where an adult is employed all or part of the year.

How many people under the age of 65 actually incur catastrophic expenses? It is estimated that 28.3 million persons use \$5,000 or more in health services in a year. Much of those expenses are paid by insurance; however, some 2.8 million pay \$5,000 or more in out-of-pocket costs, after insurance coverage.

To improve catastrophic protection for the general population, two possible approaches included in the options report would:

First, encourage State innovation and initiative in the management of health programs affecting their residents. Their understanding of the needs and problems of local areas enables States to foster catastrophic health insurance in innovative ways. States and localities could integrate the approach with existing programs for uncompensated care.

For example, States, the level of government traditionally responsible for the regulation of insurance, could consider: mandating catastrophic protection in employer-provided insurance; formation of State risk pools; loan guarantees; health insurance requirements for vehicle registration; and greater flexibility in operating Medicaid programs.

Second, tax deductions for health insurance were considered for all employers who include catastrophic health protection in their health plans. Again, the President's tax reform initiative eliminated many of the Tax Code's incentive features that narrowed the tax base, substituting lower tax rates for our citizens. With the enactment of tax reform, other options are being considered that would not narrow the tax base.

CLOSING

In closing, let me emphasize that my report put forth a range of options for your consideration, a guideline or starting point for what we expect will be a continuing dialog with Congress.

We also urge the Congress to proceed with caution. The problem is important, complex, and potentially costly to solve. It is important that we not create new problems, nor aggravate old problems while solving this one.

In addition, we caution that congressional bills should not displace the private insurance market. To help ensure consideration of costs, we urge the Congress to consult CBO and the administration to have the options priced and thoroughly worked out—between private and public sectors, all levels of government, and between insurers and all medical providers.

I believe it is possible to craft a proposal within these guidelines, and I believe it is necessary that we do so. I look forward to working with Congress.

Thank you again for allowing me to present our views on catastrophic health coverage. At this time, I would be pleased to respond to any questions you may have.

Again, I would introduce Mr. Burke, who is my chief of staff and a health economist; and, on my right, Dr. Ron Docksai, Assistant Secretary for Legislation.

Chairman STARK. Thank you very much, Mr. Secretary, for a straightforward and informative summary of the problem and potential solutions.

I would like to ask a couple of questions. The first one is prompted by this morning's press, which indicates there is somewhere abroad in the land, a plan which might require high-income seniors to spend as much as \$15,000 as a deductible before a catastrophic plan came into effect. I suspect that is just one of the many rumors floating about town, but it does bring to mind an alternative.

If one assumes that we would like to have progressivity as a feature of a catastrophic plan for seniors, it seems we have two choices: We can make the cost progressive with taxes or premiums, or, we can make the benefits progressive with higher deductibles for wealthier people.

My own view is that it is almost a matter of indifference, except that you tend to be putting that penalty on the sick, whether they are rich sick or poor sick. When you make the benefits the method through which we make the payments progressive, you are putting a little burden on those who already are carrying the burden of illness.

Therefore, I would prefer to do it through the payment structure. I wonder if you have any feelings about that.

Secretary BOWEN. Well, first let me say that I have not seen the particular plan you refer to, but that I did read about it in the paper. As I understand it, it would be income-related, and that is a possible option. I certainly welcome all options in our discussion because I believe the more we debate and discuss solution, the better the program will come out.

I admit to preferring the option in our report, but again, if they are not followed, but we still end up with a good program, fine. The

benefits, if financed by increased cost-sharing in my judgment, makes it more difficult for those who are ill, and it would be my preference to finance it the other way—through premiums. Again, it is an option, and I welcome discussions.

Chairman STARK. Thank you.

Second, I have been led to believe—and I must admit I can't establish a source, so this is both a question as to your belief, and, if you share my belief, could you help me find the citation? But it is my belief there are several medical State and local employees abroad in the land who do not now pay into the Medicare trust fund through a payroll deduction, but who eventually qualify for the Medicare benefits.

It is my understanding this may be as high as 80 percent of these State and local employees who eventually qualify through spousal benefits or outside employment. If that is the case, making those State and local employees pay what I would consider their fair share by paying the medicare tax, would be a cost savings to the program.

Can you shed any light on that?

Secretary BOWEN. Well, it is my understanding about 75 percent—I say “about;” maybe it is 80 percent, as you suggested—of State and local employees are presently covered or qualify, and that is either through voluntary agreements or by virtue of legislation that was passed for new hires. Presently, about 25 percent are not now covered, 20 or 25 percent.

Chairman STARK. I understand. I think it is that 25 percent that I am getting at.

Is it your understanding that many of that 25 percent actually will qualify through their spouses' benefits or through other employment. Have we found that historically those who have never paid into the system as a group, about 80 percent of them end up in the system getting the benefits, in effect, for free?

Secretary BOWEN. That is my understanding. But I would like to ask Tom if he has a difference of opinion on this matter.

Chairman STARK. Tom, I would love to hear your comments, if you can shed any light on it.

Mr. BURKE. I think you are correct, sir.

Chairman STARK. He said he thought I was correct.

What I would love to have is a followup, if the Department could—

Mr. BURKE. About three-quarters of those that are not now covered, we estimate, ultimately receive Medicare benefits.

Chairman STARK. I would appreciate a memo to that effect, because I feel a little uncomfortable throwing those numbers out in debate or discussion, and, quite frankly, not knowing what my source of authority is. If somebody as distinguished as Mr. Burke wants to be my source of authority, I would appreciate it.

Secretary BOWEN. The Office of Personnel Management is looking into this matter at the present time, too.

Chairman STARK. Thank you.

You mentioned the issue of State versus Federal regulation, I guess, of the insurance industry, and/or setting standards for employers when we talk about some form of catastrophic coverage for those under 65 or those who are beneficiaries of private insurance

plans. We made a tentative step in the direction of Federal controls last year by setting certain Federal standards, for employers' benefit plans, and the enforcement or penalty mechanism was the Tax Code.

I am sure you are aware that the one industry in the United States that I can think of over which the Federal Government has absolutely no controls is the insurance industry. That is a matter of indifference to me. But, if we are to begin to set some minimum Federal standards—and I think I would opt in that direction for benefits because of the high mobility of employees in an area like the District of Columbia, Virginia, Maryland, where you could move rapidly—your employment could be transferred from one of those jurisdictions to the other just at the whim of the real estate market. We would help employees if we think these standards are necessary by somehow getting a minimum Federal standard. We could do that through the tax side, or we could do it through taking the first step and beginning to regulate Federal insurance benefits.

Do you have any suggestions as to which recommendations the Department might have if we go down that path?

Secretary BOWEN. We have not discussed the necessity of any changes in the insurance regulations, which traditionally have been made at the State level. The old argument of the carrot and the stick, I guess, would come in handy here, and the encouragement of States to make the proper changes might be our preference. But it might take longer, too.

Chairman STARK. If I could just followup on that for a moment. Have you got any ideas as to what we could do to encourage the States? It would be, it seems, somewhat unpopular. I don't imagine State legislators are any more anxious than Federal legislators to run into any kind of turmoil.

What kind of encouragement could we offer the States other than just jawboning to set minimum standards?

Mr. BURKE. Well, the GAO report, which you requested, contained some recommendations along those lines. The report recommends requiring a more uniform reporting system. Currently, it is difficult to analyze insurance data at the State level, because the industry uses projected outlays, and the data are frequently not comparable between States. We are looking at the GAO report and our inspector general is working with GAO. We expect the medigap report, which we will be forwarding shortly, will have some recommendations.

Chairman STARK. Thank you very much.

Mr. BURKE. We do believe, though, the Baucus amendment has had a positive effect on the medigap industry.

Chairman STARK. We certainly look forward to any suggestions you might have, as well.

Secretary BOWEN. I am sorry. I didn't realize what you were getting at here. But the medigap report is in circulation, and it is full of good information. Our inspector general is looking at it carefully, and we will be coming up with some suggestions. The Baucus requirements are useful and have somewhat improved the situation within the medigap market. However, there are no teeth in the Baucus amendment, and putting some teeth in it might be of some help in better enforcement of the provision.

Chairman STARK. We always stand ready to give the Department of Health and Human Services any teeth it requires to enforce good measures.

My final question relates to the execution of the Federal versus private insurers in the catastrophic area, particularly in the Medicare and Medicaid programs. I have been made aware that there is some opposition among private insurers to your Department's options and some of the options that have been suggested by myself or members of our subcommittee. I have the understanding, and I wonder if you share this understanding with me, that in our Medicare system, we are returning, without bankrupting future generations, about 98 cents out of every dollar that is paid into the beneficiaries and that we do not penalize or refuse insurance to people who have preexisting conditions, which most private insurers must do. We do not age relate—the older you get and more subject to catastrophic illness, we do not raise the premium, which most private insurers must and, in fact, do.

I further understand the private insurers are returning about 60 cents on every dollar and we are doing about 50 percent better. The private insurers have had the market since 1965 and, it seems, have not provided a product that does the job.

As adamant as I am to see that private enterprise gets the first crack at the apple, I think perhaps the record shows that the Federal Government in this instance would be the better provider. Is it your feeling that my estimates of about 60 cents to the dollar in private insurance and 98 cents to the dollar in our program are correct and, further, that we could provide this catastrophic coverage? Could we provide the catastrophic coverage under any of the options at minimal or no increase in bureaucratic costs to the Government? In other words, should this be a completely self-funded proposition? I do not believe, and I ask whether you share my belief, that you would have to have a whole new layer of bureaucratic employees or that your cost in running the Department of Health and Human Services would go up and might even go down a little because the system would be somewhat simpler. Could you comment on that?

Secretary BOWEN. Well, I do not want to be unfair to the medigap industry, because some are doing a fine job and others are doing so-so and some are not doing so fine a job. But, in general, the industry is doing a pretty good job. It is true that the average, according to the GAO report, is about a 60-cent payout rate on every dollar. Again, there are some that pay more and many that pay less.

It is true that our payout rate is just a little under 98 cents on the dollar; but, again, it is not fair to compare our system to that of private sector insurance, because you are comparing apples and oranges. They have overhead that we do not, and we do have our people in place to handle the program. In the acute care program that we suggested, I do not see that it would result in any extra expense and, as you indicated it might even reduce our expenses because of a possible reduction in paperwork. However, I can't promise you that. We have been criticized about displacing the private sector market and replacing it with a public program. This action might prompt insurance companies into sharpening their

pencils and modifying their policies. They still would have the \$2,000 out-of-pocket limit to insure, plus the items and services that Medicare has never paid for, such as dental care, vision care, and drug bills.

Chairman STARK. Pharmaceuticals.

Secretary BOWEN [continuing]. And so forth. Also there is no limit as far as accepting individuals because of preexisting health conditions.

Chairman STARK. Mr. Secretary, thank you very much. I look forward to working with you and your Department and our committee.

Mr. Duncan.

Secretary BOWEN. I failed to mention, sir, one thing here that you mentioned. The plan that we had suggested would be budget neutral and would not be adding, because it is a pay-as-you-go plan, and the \$4.92 has been actuarially tested as a very sound and accurate figure.

Chairman STARK. Thank you very much.

Mr. Duncan.

Mr. DUNCAN. Thank you, Mr. Chairman.

Dr. Bowen, for the purpose of your report to the President on catastrophic illness expense, how did you define catastrophic illness expenses for the individual or family?

Secretary BOWEN. It is difficult to define. What is catastrophic in terms of expense to one family is not catastrophic to another. That is why there is some merit to making it income sensitive, but it would also complicate the administration of the entire program. We arrived at the \$2,000 cap because this seemed to be a reasonable figure that would not economically break most people and would be a figure that would keep the premium low. If you raise the \$2,000 out-of-pocket limit, the premium would even be lower. If you lower the \$2,000 out-of-pocket limit, the premium, of course, would have to be higher. About \$8 to \$10,000 health care expenses equates to the \$2,000 cap.

Mr. DUNCAN. Now, the financial catastrophes, as you describe, they are a little bit different for the elderly who are on Medicare and have fixed incomes against those who may have employer-paid coverage but are still underinsured. There is a large group of those people that have problems.

Secretary BOWEN. Yes.

Mr. DUNCAN. What guiding principle should we use on this committee in developing a policy to address the problems faced by these varying categories of individuals and families?

Secretary BOWEN. Are you primarily talking about those who are uninsured?

Mr. DUNCAN. Underinsured, that are not on Medicare but are covered by employer-paid coverages.

Secretary BOWEN. About one-quarter of those who are underinsured are employed just part of the year. About 30 to 40 percent of them are below the poverty level; but, again, another 35 or 40 percent of those have incomes that are two times the poverty level and still lack adequate insurance for catastrophic protection even though they might be able to afford it. About 90 percent of those who are uninsured work for employers who do not offer insurance

or those who are eligible for their employer's plans. So there is an area that could expand the insurance industry's market too if employers offered it.

There are about 2 million of the underinsured who are medically uninsurable. Here is where the formation of risk pools by or at the State level becomes a possible solution. Of course, many receive care from charity or bad debt and these two, combined, amount to about a \$9 billion figure. If you subtract what State and local governments pay, the cost is about \$6 billion. I believe it is also necessary to mention that the Government administers many public programs that assist many otherwise uninsured individuals. In fact, Medicaid, Medicare the Indian Health Service, the National Health Service Corps, along with the Department of Defense health system and VA health programs assist millions of individuals. There are also many grants that we, at the Federal level, have given to the States to operate the community health centers, the migrant health centers, the community service programs. There is also the disproportionate share incorporated in the Medicare DRG's that help take care of low-income persons. The alcohol, drug abuse, mental health block grants also help finance care of some persons as well. There is also legislation that you passed which Congressman Stark alluded to, requiring that group-rated and employment-related insurance provide continuation coverage for those workers who are laid off or for their widows and their families for a certain period of time.

Moreover, we still have the remaining Hill-Burton free service requirements and the State and local charitable—

Mr. DUNCAN. Would you anticipate that we would replace all those people that are covered under those programs, for example, the VA?

Secretary BOWEN. No. I was not suggesting that. I just wanted to make sure that we all knew—because I was amazed when I started making the long list of all of the things that we are doing to help take care of those people.

Mr. DUNCAN. It is a long list. Now, I understand you to say that something like 65 percent of Medicare's beneficiaries are covered by medicap. Your proposal does not anticipate that we would replace the private medigap supplemental insurance, but perhaps improve on the medigap, as Mr. Daub alluded to a while ago. But you don't anticipate that would replace that at all?

Secretary BOWEN. No. The option would still be there for the individual to make the choice of: do I want to be at risk for \$2,000 and not have any medigap or do I want medigap insurance which may cover the \$2,000 out-of-pocket limit, plus drugs and perhaps vision, dental care and other items not covered by medicare.

Mr. DUNCAN. Thank you, Dr. Bowen.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Pickle.

Mr. PICKLE. Thank you, Mr. Chairman.

Secretary Bowen, it is good to have you and your group with us this morning.

Secretary BOWEN. Thank you.

Mr. PICKLE. Tuesday evening the President expressed general support for catastrophic illness legislation, but he did not recom-

mend any specific plan or proposal. The fact that he did not endorse your plan, though you have studied it over a year and announced your options several months ago, would indicate to me that he has not endorsed your proposal. Is that your feeling?

Secretary BOWEN. Well, I do not believe that he has just offhand thrown the proposal totally out. I think that he is looking at not only our proposals, but also proposals that have been submitted by others.

Mr. PICKLE. I am trying to establish a general approach. That is where my series of questions is pointed. Since he did not recommend your plan, it would seem to me there is still a battle waging within the administration over what approach the administration will recommend. Is that correct?

Secretary BOWEN. I do not know about the battle.

Mr. PICKLE. Well, a controversy.

Secretary BOWEN. Yes. There is certainly a difference of opinion, and in my judgment there is some indecision as to which path to take. The President stated that he would shortly be submitting his recommendations. I want to underscore the fact that I know personally that he is very interested in developing a program that will work, and he wants it—

Mr. PICKLE. Secretary Bowen, we are all in agreement that the time has come, I believe, to do something about catastrophic illness. Our problem, from my standpoint, at this stage, is determining what the administration will recommend. Now, this morning you outlined some options. That is helpful and good information, but that does not give us any direction. Is the administration going to submit a specific plan and when?

Secretary BOWEN. The understanding that I have is that there will be a plan submitted and the only timetable that I have is the same timetable that you read in his statement—"Shortly I will send one up."

Mr. PICKLE. Do you anticipate then that the plan will be with a large deductible as we have heard rumors of and saw in the press this morning? Is that possibly one of the recommendations the administration will make?

Secretary BOWEN. I would doubt that it would be that much; but, again, I have not seen the plan.

Mr. PICKLE. If you doubt it will not be that much, you do anticipate there will be a proposal that will probably have that kind of approach? Those amounts might vary?

Secretary BOWEN. I am just guessing, and I would say, yes, I would guess that, but I do not know.

Mr. PICKLE. If you had to choose between that approach and what you have recommended, would you recommend your plan as the best approach?

Secretary BOWEN. Well, obviously I am prejudiced to what we have submitted. We have spent a year studying it, and in our judgment that is the best plan. But then, once again, I emphasize that even if our plan is not taken, we feel we have elevated the discussion and the debate to the level that something good is going to come out of it and soon.

Mr. PICKLE. I would agree with you that we have elevated the debate, and that is nice to think about; but we are getting down to

specifics now. I also commend you for coming before our committee at this point and being courageous enough to at least start this debate or this discussion. But we do not have a specific plan.

Let me ask you, do you prefer your option to what you hear might be recommended?

Secretary BOWEN. Well, I really cannot answer absolutely, because I have not seen any other options but those that we have studied.

Mr. PICKLE. If we do make a recommendation, I assume you will be back. Would you then advance that plan or do you think your plan is one we should use as our basic approach?

Secretary BOWEN. Once the decision is made as to what the plan is, then, as part of the administration, that will be my plan. But, again, we have published our report. It is available and it is among the options that are being debated.

Mr. PICKLE. In the rumors and comments I have read there is a general feeling by some within the administration and perhaps in the private field that your plan is, quote, an expansion of Medicare, and that it is very expensive and that costs in the first year or two will not be held in line and would make this a new entitlement. Do you consider your plan a new entitlement program?

Secretary BOWEN. No. It is an expansion of a present program. It is not a new one.

Mr. PICKLE. Do you think the premium would be sufficient; that is, your costs, the \$4.92 would be sufficient to keep the Medicare program, quote, revenue neutral, that we would not be running up huge debts?

Secretary BOWEN. Yes. I feel very strongly that it would. Our HCFA actuary has studied it and restudied it and says it would be absolutely adequate. We must also state that the \$4.92 plus the \$2,000 would be indexed to health care inflation so as to keep it budget neutral.

Mr. PICKLE. I take it that you are saying that your plan is defensible and that it would not create these big debts.

Secretary BOWEN. Right.

Mr. PICKLE. You would prefer a Government-sponsored plan more than the private industry approach; is that correct?

Secretary BOWEN. No. I think it has been misunderstood. Our proposals do not take anything away from private industry. In fact, they would stimulate the long-term care insurance market. Everybody is concentrating just on the acute care plan. Our long-term care plan is almost 100-percent private. The only thing it would do would be to reduce some Federal income; but, again, the administration is working on some other plans that would not do that, and I am not privy to what those are.

Mr. PICKLE. Let me ask you one other question because I am trying to get a feel for this whole program. If we expand Medicare to provide catastrophic coverage for the over-65 population, that would be one approach. But if we expand it to include those under 65, then we are getting into a broad field of not just catastrophic illness, but what I would call a national health insurance program.

Do you think that we should expand this catastrophic illness now to include those under 65?

Secretary BOWEN. No, I do not. We have broken our report down into three separate areas with three separate programs, because what will work for one group will not work for another group. The only expansion of a Federal program that we are talking about is the coverage of acute care for Medicare beneficiaries. The rest of it is not an expansion of Federal programs.

Mr. PICKLE. I thank you, Mr. Secretary. I have asked pointed questions, but I am trying to get the general feel from your Department, and what the administration may or may not recommend. We have a serious problem ahead of us. I am glad we are approaching the problem, and I think this Congress should and will do something about it. I would hope that you would give us your specific recommendation a little later when you are in a position to do that, and I look forward to that.

Thank you.

Secretary BOWEN. Thank you, sir.

Chairman STARK. Thank you, Mr. Pickle, Mr. Secretary.

I am going to as a guide to members—I am sorry; it was an oversight on my part—run our time lights to help the members guide themselves because we have quite a few here who would like to inquire and the Secretary must leave at noon. So if we are going to accommodate all those who wish to inquire, we will have to move right along.

Mr. Downey.

Mr. DOWNEY. Thank you, Mr. Chairman.

Dr. Bowen, let me just say that I have had a brief opportunity to review your proposal, and I think it is a very good first step, but I, like Mr. Pickle, have some concerns about what appears to be happening inside the administration. Maybe you could illuminate some of the decision points and the milestones for us so we can determine when, in fact, we are going to take a look at a plan. Who else writes up and makes proposals on what sort of catastrophic plan? Does Mr. Sprinkel do that? Does he have the knowledge to do this sort of work? Does Mr. Weinberger? Does Mr. Shultz? Who else works on this in the administration?

Secretary BOWEN. I do not know that I can state names. I can state that we had the opportunity to submit our report to the Domestic Policy Council on three separate occasions. We presented the substance of our report in front of the Cabinet and the President on two separate occasions. It is obvious that there is not unanimity of opinion.

Mr. DOWNEY. Sure.

Secretary BOWEN. And those who were opposed to the method that we had suggested in our report are submitting their own report.

Mr. DOWNEY. Who are they and how do they do this? I am curious to know—I do not want you to divulge any secrets, but this is a fairly important plan. I suspect that you have got to have access to health data and health information to do this. Who else is going to come up with a plan inside the Domestic Policy Council? Who else is prepared or equipped to do that?

Secretary BOWEN. Well, I do not know that I can give you any specific names other than those you have read in the newspaper.

Mr. DOWNEY. Are you telling us there is a secret plan here for health care that is going to emerge at some point? I have not read all the articles. Tell me who else is involved in this. Is Mr. Sprinkel going to come up with a plan for us?

Secretary BOWEN. I do not know. I have not seen any of the plans. I have not seen any signatures.

Mr. DOWNEY. How about Secretary Brock? Is the Secretary of Labor going to do one?

Secretary BOWEN. I have not seen any of the plans nor any signatures as to whose plans they are.

Mr. DOWNEY. Well, let me ask you then some questions. I find this kind of curious, you being the Secretary for Health and Human Services not being aware of the other plans. Hopefully, we will have something like your plan.

Mr. BURKE. Congressman, that is not totally correct. We have looked at a number of options that have been prepared by a working group at the White House with representatives of all of the Cabinet members who have their health staffs participate in the working group which is chaired by Dr. Roper from our Department. They have surfaced options. We have been privy to those options. We have reacted to those options. We, in the Department, still think our options are preferable and we have pointed them out. Reasonable men can differ.

Mr. DOWNEY. Sure.

Mr. BURKE. We have a difference.

Mr. DOWNEY. When do you think the difference is going to be resolved? I have heard the adjective "soon." What does that mean? What is "soon"? Weeks? Months?

Mr. BURKE. Weeks, I would suspect.

Mr. DOWNEY. Weeks. So that we could maybe see a proposal by March? Is that too soon?

Secretary BOWEN. The President specifically said "shortly." That is different than "soon."

Mr. PICKLE. I beg your pardon. What date were you saying?

Mr. DOWNEY. Soon. Shortly or soon. Can I ask about this \$2,000 out-of-pocket limit? Do you, Mr. Secretary, believe that people with incomes of \$10,000 could afford a \$2,000 limit on out-of-pocket expenses under your proposal?

Secretary BOWEN. It would be difficult, obviously, for the small percentage of those who would be at risk for that. You are always going to have a group of people, that borderline, and it makes it difficult for them.

Mr. BURKE. We are looking at a \$2,000 out-of-pocket which, as we said, translates to anywhere from \$8 to \$10,000 in covered medical expenses. That would be spread over the entire Medicare population. There are options. There are bells and whistles that could be put on our report to handle the people. One of the options would be to let the States cover catastrophic expenses, which would be advantageous to them, to pay the premium for the catastrophic coverage. They now buy in for Medicaid.

Mr. DOWNEY. Your proposal requires a \$4.92 a month premium in the first year, as I understand it. What premium are you projecting in the out year?

Mr. BURKE. The premium is actuarially sound and it is difficult to project it for this reason. It is an experience-rated premium; that is, it is based on utilization. Therefore, the premium could conceivably go up or go down. The cap is indexed for inflation. The trend in past years has been that the number of days of hospitalization exceeding 90, for which we would cover the cost sharing, have, in fact, been declining in recent years since the introduction of prospective payment. So it is not inconceivable, or even unlikely, that the premium could, in fact, come down.

Mr. DOWNEY. The catastrophic benefit should be a voluntary program?

Mr. BURKE. It is a voluntary program. Part B is an optional program.

Mr. DOWNEY. Thank you, Mr. Chairman.

Chairman STARK. Mr. Daub.

Mr. DAUB. Thank you, Mr. Chairman.

I have been looking for some time at both the initial recommendation and then the subsequent modified recommendation, the one that is indicated at this point as your preference, without comparing it to other plans that may surface for a unified administration effort to solve the problem.

Dr. Bowen, I particularly appreciated your testimony. I thought it was well prepared and well delivered. I thought the data contained in it demonstrated the need and articulated some of the statistics and facts that have not been focused on by many. So I really want to tell you that I thought your testimony was very well prepared for this full committee hearing.

I am concerned, of course, that the acute care expansion may become a stalking horse for universal or nationalized health insurance, or some larger program often considered to be very expensive. Indeed, from a health care point of view, these are ideas that have been rejected for many years and probably have a better reason for being rejected now than ever before.

I have been looking at options and alternatives as well, and I hope in the next couple of weeks to bring to your shop a comprehensive plan that has catastrophic limits on part A and on part B, without necessarily expanding either one from current definition, although the current acute expansion you are supporting here would certainly be acceptable as a part of that as far as I am concerned, and add a part C, not the kind of part C that Sasser and Roybal and others have been talking about, but looking somewhat at an income-related scale to look at some long-term care, home health, and drug care. And part of your voluntary ideas that might be included are the use of noncore interest income, both below age 65 and over age 65, if devoted to the premium for a specifically defined kind of long-term or catastrophic insurance package, perhaps not IMA or the IRA or some other thing, but just let everybody have the opportunity to use up, for example, their first \$2,000 of interest income at any age if it is devoted to the purchase of some kind of long-term package; beyond that we could modify pension rules.

We on this committee would have to look at the Tax Code as a means to modify the income stream of the elderly's pension plans. Right now benefit plans cannot combine because they cannot by

law, put both acute and/or long-term care into a package for a private group plan of some kind. These ideas will be modifications by statute that I will be suggesting to our subcommittee, as well as to you. I thought that the article in the paper this morning might not be far off in one dimension, that truly catastrophic long-term care as opposed to acute care might be looked at at this time and let the private sector have that whole ball game and take the lead. We should encourage people to save for their old age. That includes anticipated costs of health care. If they are below \$10,000 in income or in that range, of course, Medicaid, as you pointed out, takes care of those concerns.

Let me ask you three very quick and specific questions.

Do you have a report or a data file that could be shared with the committee that actually describes for us how the \$4.92 was arrived at so that we do not take time to ask you what the specifics of that were?

Secretary BOWEN. Yes, and we will submit it for the record.

[The following was subsequently received:]

METHODOLOGY OF ESTIMATING CATASTROPHIC COVERAGE PREMIUM

To determine the catastrophic coverage premium, a computer model was constructed. The model projects the medical expenditure of each individual in the sample from the base year to the target year. Beneficiary's out-of-pocket liabilities under the present law benefit structure and under the catastrophic coverage proposal were then determined. The difference between these two out-of-pocket liabilities represents the additional cost arising from the new and restructured Medicare benefits. By aggregating the additional costs for all beneficiaries in the sample and then expanding it by the right proportion to represent the entire Medicare population, the total added cost was determined which is to be funded through a premium paid by all enrollees in the Part B program. Such a premium is obtained by dividing the total additional cost by the number of Part B enrollees. Note that the premium so determined is the benefit premium. It does not include any increase in the ongoing administrative expenses associated with the new benefits. Nor does it include any cost needed to set up a new, or to modify the existing data collection and processing system to monitor the restructured benefits.

The data file used is a one percent sample of Medicare enrollees who received benefits in calendar year 1983. It includes records for 198,300 individuals. Each record contains certain demographic information along with utilization data of medical services in 1983, such as number of hospital admissions, number of inpatient days, amount of Part A reimbursement, amount of Part B reimbursement, etc.

In projecting the base year data to the target year, changes in the Medicare program that took effect during or after the base year which had significant impact on reimbursement or utilization were taken into consideration. Time trends in utilization and unit cost of major types of medical services were also reflected in the projection. These adjustments were determined in such a way that in the aggregate the projected values of certain major parameters closely match those in the 1986 Trustees' Report.

Liberalization of benefits always carries the risk of encouraging utilization of services, either because of beneficiaries' own initiatives or because of providers' behavior, especially when beneficiaries' out-of-pocket expenses are near or over the cap. However, trying to estimate the extent of such induced utilization because of behavioral changes is inherently difficult. To compensate the potential of induced utilization, a small margin of five percent was added to the rate.

The final premium for the Bowen proposal was \$4.92 a month for calendar year 1987. If the proposal is not implemented until 1988 or later, the premium will be higher.

To illustrate the approach described above, the derivation of the \$4.92 monthly premium is presented below.

1987 projection

1. Number of Part A deductibles under present law	8,156,600
2. Number of inpatient coinsurance days	2,776,200
3. Number of lifetime reserve days	1,057,300
4. Number of SNF coinsurance days	4,901,800
5. Part A out-of-pocket expenses under present law $= (1) \times 520 + (2) \times 130 + (3) \times 260 + (4) \times 65$	\$5,196 million
6. Part B out-of-pocket expenses under present law	9,228 million
7. Combined out-of-pocket expenses under present law	14,424 million
8. Combined out-of-pocket expenses under catastrophic proposal	12,906 million
9. Reduction in beneficiaries' out-of-pocket expenses $= (7) - (8)$	1,518 million
10. Estimated cost for 365-day inpatient benefit	240 million
11. 5% margin	88 million
12. Total net cost $= (9) + (10) + (11)$	1,846 million
13. Number of Part B enrollees	31.5 million
14. Net annual premium $= (12) / (13)$	\$59
15. Net monthly premium $= (14) / 12$	\$4.92

Mr. DAUB. Could you let us have the benefit of your track that arrives at the \$4.92? I am pleased to see it is indexed, and I think that is a useful balancing idea. I am concerned that \$60 a year might, when added to the voluntary premiums Mr. Burke pointed out that are currently paid, cause some falloff on the other end; that is to say, have you looked at whether or not that extra \$5 a month may cause people to not choose the part B premium at all?

Secretary BOWEN. I do not know of any statistics available on that, but it seems that Medicare part B is probably the best bargain that the Federal Government has to offer. I can hardly see anybody dropping off when they are going to get very inexpensive catastrophic coverage added to it.

Mr. DAUB. Might not we start to think about that \$4.92 and going to \$5.92 or \$6.92 or \$7 or \$8 if the threshold, for example, is dropped from \$2,000 to \$1,000? The premium will become more expensive, will it not?

Secretary BOWEN. If fewer people take it, it would be, yes.

Mr. DAUB. But we are not going to offer the \$4.92 separately. Are we going to let people pick and choose? They can take current part B coverage and if they want expanded part B they pay the additional? Your idea is they pay it all in one lump sum, correct?

Secretary BOWEN. Right.

Mr. DAUB. I want to say, as the debate proceeds, the more we intend to do by either expanding benefits or dropping the catastrophic threshold, we certainly have to take into account that people may find the whole part B premium becoming more expensive than they can afford. That would be a concern.

Secretary BOWEN. That is a concern, but I do not think it would happen. But that is just my judgment.

Mr. DAUB. I appreciate that. I have one last question. In discussing with many of my constituents, I have discovered they perceive catastrophic perhaps not so much in the cost of their premium and their deductibles but in the hidden costs that they are hit with when their bill arrives and they discover that Medicare paid only 80 percent of the approved charge and not 80 percent of the actual or billed charge. Do your recommendations for restructuring of part A and part B take into account this growing beneficiary liability between approved and actual charges and would the beneficiary continue to be liable for these differences or is this considered in your \$2,000 cap?

Mr. BURKE. Congressman, was that not fixed to some extent last year with the maximum balance billing limited to 15 percent? So the gap cannot be continually increase. There is a maximum 15-percent limit on balanced billing that physicians or other providers can, in fact, bill the Medicare beneficiary.

Mr. DAUB. Under part B, I will submit to you about 15 examples I have been given from actual files pulled.

Mr. BURKE. This has happened in the past, but——

Mr. DAUB. Where you have a \$10,000 billing under part B, they approve for Medicare purposes \$4,000 or \$5,000, subtracting 20 percent from that, and all I am trying to get at is isn't that gap still there? It is not solved, is it, by your plan?

Mr. BURKE. I think your committee fixed it last year, Congressman.

Mr. DAUB. But at any rate, we don't solve—the \$2,000 as a threshold does not begin to address this, does it?

Mr. BURKE. The \$2,000 threshold does not address the issue of balanced billing.

Mr. DAUB. Thank you very much.

Mr. BURKE. That is not a covered expense.

Mr. DAUB. Yes. I am just trying to establish that for the record.

Mr. Chairman, thank you.

Mr. Secretary, again, I am very interested in the catastrophic plan. I think the administration has taken the lead and they deserve credit for it. You are particularly courageous, and we will be talking with you a lot and looking for help and assistance and cooperation; and, again, thank you for being here today.

Secretary BOWEN. Thank you.

Chairman STARK. Mr. Coyne.

Mr. COYNE. Thank you, Mr. Chairman.

Dr. Bowen, do you have any figures as to what the average premium is for a medigap policy?

Secretary BOWEN. The average premium, as I understand it, is between \$500 to \$600. There are some lower and some much higher.

Mr. COYNE. Five or six hundred per?

Secretary BOWEN. Per individual, per year.

Mr. COYNE. Per year. Does that figure reflect any long-term coverage?

Secretary BOWEN. No, it does not.

Mr. COYNE. Does not include long-term coverage?

Secretary BOWEN. No.

Mr. COYNE. Thank you.

Secretary BOWEN. About 1.4 percent of nursing home bills—between 1.4 and 1.7; we have seen both figures—are paid by private insurance.

Mr. COYNE. Thank you.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Thank you very much.

Mr. Secretary, welcome. As a new member I am glad to be here to join you in looking at this critical issue.

Let me start, if I might, with a larger question. Why start with acute care rather than long term?

Secretary BOWEN. Well, we have not recommended that you just start with acute care. Our report lists three different groups that must be considered, each with different problems and each requiring different solutions. Acute care for the elderly, the Medicare age, is a far different problem than long-term care. Then the third group are those under the age of 65. We believe that they require different solutions, so we have not made proposals for just acute care. We would like to see all proposals go forward, but I suppose acute care is probably the quickest fix and can be done easier than long-term care.

Mr. LEVIN. So that is why the thrust of your proposal in terms of legislation relates to acute care?

Secretary BOWEN. We have not tried to make it the thrust. Everybody else has made it the thrust.

Mr. LEVIN. Well, the program, the \$4.92, would relate to acute care, right?

Secretary BOWEN. Right. That is acute care only.

Mr. LEVIN. That is the reason for the focus, because the first major issue would come through that premium, through that package.

Now, I do not disagree with it, but I think it is useful to articulate why, in terms of a major new initiative, it is focusing on that aspect.

Secretary BOWEN. It would bring peace of mind to 30 million people, because they are worrying about two things: their health and their finances, and wondering which one is going to run out first. This attacks one portion of that problem.

Mr. LEVIN. All right. Let me, play the devil's advocate for a moment, you have had this discussion within the administration. Your testimony says medigap covers 65 percent in part or in whole, mostly in part. You also say later on that the public program should not displace the private program. So my question is why, where there is a system or a structure or a condition where a private insurance structure covers in whole or in part 65 percent, should there be any Federal involvement, any governmental involvement? What have you said within the discussions in the White House? What are you saying to your adversaries?

Secretary BOWEN. Well, first of all, approximately 35 percent of the Medicare population are not covered at all by medigap, and that is a sizable number when you are considering 30 million people. Thirteen percent, I believe, are Medicaid eligible. Sixty-five percent have medigap and about another 22 percent or so have no coverage at all. The cost for the program that we have suggested is \$4.92 a month or \$59 a year and that could be compared favorably to the medigap annual costs, as you asked a while ago. The choice is for the individual then, do I want to pay my \$59 for the year and be at risk for the \$2,000 or do I want to pay my \$4.92 and continue to have a medigap policy which will still cover the \$2,000 plus cover the things that Medicare now does not cover. That is an individual choice.

Mr. BURKE. I think the other important thing to point out is that—

Mr. LEVIN. If you would speak right into the mike, because this is important.

Mr. BURKE. The proposal is an attempt to fill a gap that currently exists in Medicare. And this gap is filled by a marginal cost that is very small to the Federal Government. It is marginal cost pricing. That is what makes it a much better bargain.

No one is advocating unnecessary expansion of a program, but in this instance it is justifiable based on the low marginal cost. The Medicare claim is going to be paid anyway. If you are in the hospital for 65 days, for example, it simplifies it if you have one claim. The provider has one claim to fill out, and the cost to Medicare is no greater in processing a claim for 65 days than for 59 days.

Mr. LEVIN. So your answer has been that it will expand coverage in a highly economic way without a lot of added cost.

Isn't it true there would be some displacement of private insurance?

Mr. BURKE. You could call it displacement, but the argument is focused on the acute aspect of our report to the exclusion of the rest of our report. I think there is some innovative thinking in the rest of our report which has suffered as a result of this focus. We have proposed a number of incentives that will provide an expanded market for the insurance industry to begin to start offering coverages which are not now there for long-term care.

We would also allow greater competition for the existing gaps which are still there. And, from the point of view of the elderly, some of their major concerns are pharmaceuticals, preventive care, excluded benefits, and long-term care.

So I think in a way we are stimulating the private insurance market, but in a different direction.

Mr. LEVIN. Mr. Chairman, I am afraid my time is up.

By the way, Mr. Matsui had wanted to be here, and I have a note that he is not able to; that he has a statement that he would like inserted in the record. If I might, could I ask unanimous consent Mr. Matsui's statement be inserted in the record?

Mr. PEASE [presiding]. Without objection, so ordered.

Mr. Ford also has a statement he would like inserted in the record. Without objection, that will be inserted. So ordered.

[The opening statements appear at pp. 8 and 9.]

Mr. PEASE. Mr. Gregg.

Mr. GREGG. Thank you.

I would like to follow up on that part of the report you were just discussing, which is long-term care and the part that hasn't gotten the attention.

What is the situation with long-term care? Can you run through that proposal again, and why you think it is going to attract private insurers?

Secretary BOWEN. We have about three suggestions on long-term care. First of all, there needs to be a far-reaching education program to notify individuals as to what is covered and what is not covered under Medicare and medigap. The AARP survey revealed that two out of three of their membership did not know that Medicare did not cover long-term care. So, an educational program is the big start that must be done.

Second, we would encourage savings programs, such as an individual medical account, but coupled with an insurance program. I would like to describe this idea just a little because I think it is a very innovative recommendation which would stimulate the insurance industry.

An individual could pay into a plan \$1,000 a year for 24 years—this sum would be placed in an individual medical account—it would be placed in any bank associated with one or more insurance companies. The IMA would be divided into two parts, the principal and interest, subdivide the interest into two parts, 50 percent which would continue to accumulate to the principal and the other 50 percent would be used to purchase a long-term care policy. Then, if an individual at the age of 65 should suddenly pass away and not have any need for long-term care, the principal plus 50 percent of the interest would revert to his or her heirs.

If, at the age of 65, or any time thereafter, long-term care were needed, the principal and the 50 percent of the interest accruing on the principal would be utilized for the long-term care.

Then, if that were used up, and that would take approximately 16 to 22 months, then the insurance policy would kick in, and that would take care of another 6 to 8 months. This type of plan could take care of about 82 to 85 percent of all of the cases in a nursing home.

If, at the time, they were still in a nursing home when those two were used up, then they would have to use up their own private savings, CD's, and so forth. And then, if they were still in, then they would be a candidate for Medicaid.

Mr. GREGG. You are talking, then, about a 24-year or 23-year lag time before this is—

Secretary BOWEN. We have stated in our report that you have to look way into the future. But even if there were just 10 years involved, it would still be utilized.

Mr. GREGG. Would these accounts be tax-deductible?

Secretary BOWEN. Our plan suggested some tax favoring comparable to what an IRA has.

Mr. GREGG. What is the cost of long-term care? Do you have a dollar figure for that that you estimate it at on an annual basis?

Secretary BOWEN. The total cost for long-term care? It averages for a nursing home stay about \$22,000 a year. There are about 1.4 million in a nursing home at any one time, 500,000 of which are Medicaid patients, and 1.4 to 1.7 percent pay through private insurance, and the rest pay out of their own pockets.

Mr. GREGG. How do you dovetail the Medicaid cost, which is now being borne by society generally, into your program? Is that just phased out? Is this Medicaid no longer a program if the 1-year program got up and running?

Secretary BOWEN. I am sorry?

Mr. GREGG. When your long-term care program and your insurance accounts kicked in, and the system was functioning, is Medicaid then just a cost to the Government that no longer exists?

Secretary BOWEN. There would still be a Medicaid program, but the incidence of spending down to the Medicaid level would be greatly reduced under this plan, simply because now, within 3 to 6 months, the average individual entering a nursing home has spent down to the Medicaid level. So the plan would greatly reduce—

Mr. GREGG. It would extend that. Only 16 percent of the people then would be going on to Medicaid under your program, because you said 82 percent of the people would be covered by your program?

Secretary BOWEN. I don't know how many. Tom, maybe could answer that.

Mr. BURKE. In answer to your question, I don't anticipate, or we don't anticipate, that there will be any change in the numbers. The rationale for the proposal, though—you mentioned the 23-year leadtime—it could be something less than that, but that is essentially what we are talking about.

The rationale for that is that will be the period of time in which the baby boom will be coming on line as an elder boom. To the extent that this program is adopted, these people would be less

likely to spend down to Medicaid. If we do not do something and they do in fact spend down to Medicaid, then you are looking at a massive expansion of Medicaid in the outyears.

Mr. GREGG. On another subject completely, what does the loss of the catastrophic part of medigap coverage, the acute catastrophic loss—how much does that affect the premium for medigap? In other words, that \$500-a-year premium you are talking about, how much will that drop, theoretically, if you do not have that coverage any longer borne by medigap?

Secretary BOWEN. How much would the medigap drop?

Mr. GREGG. How much would the medigap premium drop in price, would you estimate?

Secretary BOWEN. I would estimate it would drop \$200 to \$400. I am just guessing.

Mr. GREGG. \$200 to \$400?

Secretary BOWEN. Yes.

Mr. GREGG. So, the medigap premium for all the other items it would cover, now instead of being an average of \$500, would be \$150 to \$250?

Mr. BURKE. That would depend on the type of coverage. Medigap is not a homogeneous commodity.

Mr. GREGG. I know that.

Mr. BURKE. Some of them now have extensive drug programs for which the premium is quite high. Others have restricted drug coverages, and the premiums are correspondingly lower. A pure medigap wraparound, however, could possibly be significantly cheaper with this in place.

Mr. GREGG. Thank you.

Chairman STARK. Mr. Levin, you have inquired.

Mr. PEASE.

Mr. PEASE. Thank you very much, Mr. Chairman.

Dr. Bowen, I am delighted to have you here, and appreciate your testimony.

The configuration of this dais is not well-designed for people who barely make it up on the upper tier. I am delighted to have you here, and I would agree with you that your efforts over the last year have, indeed, elevated significantly in the public eye the serious problem of catastrophic health coverage. This is a problem that has been with us for a long time, and I think it is very much to your credit that it is now very high on the agenda of the Federal Government.

A couple of questions. As I understand it, under your recommendation, the entire cost would be paid by the premiums; is that correct?

Secretary BOWEN. For the acute care for the elderly, yes.

Mr. PEASE. For the long-term acute care?

Secretary BOWEN. It would be a pay-as-you-go, budget-neutral proposal.

Mr. PEASE. It would be optional. People could choose it or not choose it.

Secretary BOWEN. Well, I think that needs a little explanation. It would be added to the part B premium, and by law the part B premium is optional. However, most people do elect to take it.

Mr. PEASE. So, if a senior citizen wanted to take part B, he or she would get the catastrophic coverage, whether he or she wanted it or not; is that correct?

Secretary BOWEN. That is correct.

Mr. PEASE. So you could not choose part B, but not catastrophic coverage?

Secretary BOWEN. Yes.

Mr. PEASE. Well, that would probably take care of the concern that I wanted to raise with you, and that was: If just that part of it were truly optional, those with serious health problems would select that program, and you would have disproportionately high costs.

Secretary BOWEN. And, conversely, the fewer that took it, the higher your rate would have to be. It could not be as low as \$4.92. The only way it can be approximately \$4.92 is the fact that about 30 million people would be taking it.

Mr. PEASE. What percentage of retirees currently take part B?

Secretary BOWEN. I think it is around 95-97 percent.

Mr. PEASE. So you would not anticipate any serious erosion in that percentage?

Secretary BOWEN. I would not, no.

Mr. PEASE. Could I ask you generally, what is your attitude toward making the payments for this program, or for catastrophic coverage, what they call income-sensitive—that is, varying the cost according to the means of the senior citizen?

Secretary BOWEN. That is an option, and we have that as one of our options, which is an alternative to our preferred approach. It is cost-sharing with or without income consideration.

Mr. PEASE. That is one of the options? You did not choose that option?

Secretary BOWEN. It is in our report as an alternative option.

Mr. PEASE. I see.

Do you think it is generally desirable, or undesirable, to tie the cost of a program like this to the ability to pay of the recipient?

Secretary BOWEN. Let me say this my absolute personal opinion—I think it is a reasonable thing to do. What is catastrophic to one individual certainly is not catastrophic to another.

However, an income related program would make the administration of the program very difficult.

Mr. PEASE. It probably would, because a number of senior citizens, probably a majority, don't file Federal income tax returns. I was thinking that one possibility might be charging a percentage of a person's income. For those who file Federal income tax returns, that would be fairly easy to calculate. But it would be a problem for those who do not file returns.

Well, I appreciate your testimony this morning. I do find it a little strange that there is a two-track operation going on with the administration. I would think that the President would grant you, as his Secretary of Health and Human Services, the courtesy of making you an integral part of these explorations for alternatives. Apparently, it is taking place on a different path.

I regret that. But I think at the end, working with you and the other part of the administration, we in the Congress hopefully will come up with a sound plan that everybody can support.

Thank you.

Mr. DONNELLY [presiding]. Mr. Chandler.

Mr. CHANDLER. Thank you, Mr. Chairman.

Mr. Secretary, I think that there is—I won't presume there is; I will ask you if you think there is—an ethical aspect to this whole issue in terms of who receives care. Clearly, if we are looking at a 95-year-old individual and a medical option is open-heart surgery, it is obviously an ethical question, whether to proceed or not.

Given the expense of this type of care and what appears to me to be the obvious question of ethics involved here, how do you feel the Congress should approach this question? How can we be rational about a very emotional subject? Or is this even a question? To whom should this be referred? How do we debate it? Is it part of your report? Should it be?

Secretary BOWEN. It is not part of our report, and I am not so sure it should be. I don't know how to advise you to approach that, because it is a most sensitive issue.

I think the medical profession and all the health care providers, irrespective of who they are, will want to be as accurate and compassionate, but yet, have as much commonsense in their judgments as possible. And I can't conceive of recommendations for heart transplants in a 95-year-old individual.

Mr. CHANDLER. I can't, either. But I think there has been evidence that that sort of thing has been done in the past. And I am wondering if there is the danger of diverting resources from perhaps younger, treatable individuals to those who are beyond, or approaching being beyond care, just by the very fact that the resources are available to the medical community.

Secretary BOWEN. I think the prospective payment system, DRG's, and peer review groups could handle that problem quite well, because they are charged with appropriateness of care, appropriateness of admissions, and so forth. I think their judgment would be satisfactory now.

Mr. CHANDLER. If I could ask one more question, Mr. Chairman.

On the \$4.92 premium, given the demographic projections—and you cite at least one of them in your testimony—the growing number of persons over the age of 85; and, clearly, the baby boom becomes the elderly boom of the first few years of the 21st century—I am wondering how that squares with the projection that you might even see the premium reduced when it is very clear that the need for services is going to increase.

Mr. BURKE. I said it is conceivable that the premium could go either way. The premise that I built that on was that the number of hospital stays since the inception of the prospective payment in 1983, where we have 120 to 130 consecutive days in a hospital, have been declining. Those are the days that we would be paying for with the premium. We would be paying the coinsured components of that.

I think the likelihood of this occurring with the aging population under a catastrophic program is not likely to be any greater. We would have an actuarially sound premium. If the experience were such this did occur, the premium would be adjusted in subsequent years to reflect that.

Mr. CHANDLER. Thank you.

Mr. DONNELLY. Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

And thank you, Mr. Secretary, not only for your appearance here today but for your leadership on this important issue.

My only personal disappointment with what has been said so far about this issue is that I don't think we have gone far enough in terms of setting a national goal on this issue. In my personal opinion, we should be setting forth as a goal to be achieved, not immediately but over a period of years, protecting all American families against the cost of catastrophic illnesses.

I don't see this as necessarily a government-all solution, but a matter of government working with employers and individuals to come up with a strategy, not limited to the elderly and not limited to acute care. But we have to start where we are; and, believe me, as I look at alternative plans, your original plan looks better all the time. I really mean that sincerely. You gave it a lot of thought, and it stood the test of time very clearly.

As these options are considered, I just would like to indicate for myself that one of the things that I look at to test a particular plan is how it treats low-income elderly who are not eligible; that is, they are low income but not low enough to qualify for Medicaid. That is a group that is largely not covered by medigap today. I think unless we have a scheme that provides for that group, in my opinion we won't really have done the job.

Following the State of the Union Message, which the President gave the other night, the White House put out a two-page statement headed, "The President's Initiative on Catastrophic Illness Coverage," which included four guidelines. I want to read these into the record. They are very short.

We must provide meaningful protection against out-of-pocket expenses that substantially threaten family savings.

Second, the importance of Medicare, Medicaid, and medigap should be maintained; and we should not encourage excessive use of services.

Third, any catastrophic illness coverage should be voluntary, not a new government entitlement.

And, fourth, the proposal must be fully budget-neutral without the explosive potential of program expansions.

Good luck. In honesty, I don't see any way to do all four of those in the same bill. Maybe there is, and we will find out. I think there are some inconsistencies that are inevitable in trying to do it this way.

In particular, I don't see how a voluntary program, a totally voluntary program, can give assured protection to all the elderly. I don't mean to quibble. I am looking forward to your recommendations.

Mr. Chairman, I understand there are several members of the full committee who are not present today who have some questions, and they would like to submit for the record and for written responses. And I would request, Mr. Chairman, that if members of the full committee, subsequent to this hearing, have questions that they make available in writing, that they be included in the record, and that a request be made to the department for a written response to those questions.

Mr. DONNELLY. Without objection, we can put a 5-day time limit on that.

Mr. GRADISON. Extremely fair. Thank you, Mr. Chairman.
[The following was subsequently received:]



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Office of the Assistant Secretary
for Legislation
Washington, D.C. 20201

April 16, 1987

The Honorable Fortney H. Stark
Chairman
Subcommittee on Health
Committee on Ways and Means
1114 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Chairman:

I have enclosed a copy of the responses to the questions that Rep. Crane submitted for your Health Subcommittee's January 29 hearing on catastrophic illness expenses.

Please do not hesitate to call on us if there are any questions.

Sincerely,

Patricia Knight
Deputy Assistant Secretary
for Legislation (Health)

Enclosures

1. Question:

What I would like to know is, of the 28 million Medicare beneficiaries, how many actually spend down all of their Medicare coverage? How many of these 28 million elderly incur out-of-pocket expenses for acute care which are not covered by any private insurance policy they might have and which amounts to over 30% of their annual income? How many of these 28 million incur catastrophic acute care costs which cause them to spend down all of their resources?

Answer:

The number of Medicare beneficiaries who actually incur catastrophic level expenses is relatively small. We have good data regarding the numbers of beneficiaries who experience differing levels of liability for copayments required by Medicare, e.g., those whose liability exceeds \$1000, \$2000, \$3000, etc., and those who use expensive hospital coinsurance days or exhaust benefits. However, we are not able to determine for each of these beneficiaries who has other private coverage including the extent of that coverage or their personal financial status. We do know that approximately 20% of the beneficiary population, generally those in lower income levels, have no other insurance protection beyond Medicare and they represent those most vulnerable to financial catastrophe.

Approximately 6,000 beneficiaries exhausted the hospital insurance protection under Medicare in 1984. Unless they subsequently were able to begin a new benefit period they would no longer have this important protection.

2. Question:

Would your proposal that Medicare be restructured to provide catastrophic protection financed by an additional premium of \$4.92 per month cover a Medicare beneficiary's long-term care costs, such as nursing home costs?

Answer:

The premium of \$4.92 per month which represented estimated program costs in 1987. The Administration's proposal for 1988 would be financed by a premium of about \$6 per month (excluding the carryover provision). This proposal would limit out-of-pocket expenses for inpatient hospital services and Part B medical services to \$2,000 per year in 1988. Up to 100 days of skilled nursing facility care would be free from coinsurance payments. As for long-term nursing home care, the Administration directed the Department of the Treasury and others to study ways of meeting such costs.

3. **Question:**

Would this additional \$4.92 premium cover doctor's charges in excess of reimbursable fees?

Answer:

Assuming the \$2000 limit is met, the program would cover coinsurances based on the "Approved Medicare Charges." It would not cover those charges a doctor may make in excess of the charge approved by Medicare.

4. **Question:**

Would prescription drugs, eyeglasses, hearing aids, and other such medical costs commonly incurred by the elderly be covered by this additional \$4.92 premium?

Answer:

There would be no changes in current coverage rules for Medicare, thus prescription drugs, hearing aids, etc., would continue to be non-covered services and the beneficiary's out-of-pocket expenditures for these items would not count toward the \$2,000 limit.

5. **Question:**

Given the medical community's ethical obligation to seek life-sustaining treatment, would your proposal cover the costs of sustaining a "brain dead" individual's life indefinitely? Given the increasing costs for life-sustaining measures, at what point would you suggest this new coverage you proposed stop covering life-sustaining measures?

Answer:

The catastrophic proposal does not extend new coverage or change the method by which hospital and medical services are approved for coverage and for reimbursement. Therefore, life-sustaining treatment considered medically necessary and provided to patients under today's program could also be provided in a restructured program. The decision regarding the appropriateness of such care remains a medical issue to be decided by the physician and patient or patient's family.

6. **Question:**

Does your proposal address the impending bankruptcy in the Medicare system which has been predicted in the annual report of the Medicare Board of Trustees?

Answer:

A critical factor that influenced our development and evaluation of all options for reducing the risk of catastrophic health expenses for Medicare beneficiaries, including the President's proposal, was the need to insure that there would be no escalation of Federal deficits or further erosion of the Medicare Trust Fund. While the objective of our catastrophic study was not to address projected short-falls in Medicare financing, we were ever cognizant of the premise that any solutions developed could not exacerbate existing fiscal concerns. (i.e., must be self-financing and budget neutral).

To provide improved catastrophic protection at the risk of jeopardizing the future fiscal integrity of the Medicare Trust Funds would be irresponsible and of questionable assistance to the future Medicare beneficiary population.

7. Question:

You propose that the \$2,000 cap on medical expenses be allowed to increase as health care costs increase. Do the actuarial assumptions about the long-term costs of your proposal include the assumption that Congress will allow this cap to increase with this inflation index?

Answer:

We propose to index the initial \$2,000 cap on medical expenses to the percentage change in Medicare per capita expenses for years after 1988. If the cap was not allowed to increase overtime, the required premium necessary to cover the costs of the enhanced benefits could rise at a more substantial rate. For this reason we believe it is important that the cap reflect annual changes in Medicare per capita expenses.

8. Question:

Given Congress' propensity to hold down the increase in deductibles included in entitlement programs, such as last year's Congressional action to hold the full Medicare Part A deductible down to \$520 and the freeze in the Supplemental Medical Insurance premium at FY 1982 levels, upon what past Congressional actions do you base your assumption?

Answer:

The catastrophic proposal we have offered addresses an important and needed improvement in the health care protection of Medicare beneficiaries. As with any improvement in health insurance protection there are costs to be borne. However, because relatively few beneficiaries

actually experience catastrophic expenses the cost of the protection necessary to assure piece of mind to all beneficiaries can be kept low. It is important that all who will benefit from the increased protection share in its cost. A critical factor influencing our development of this proposal was the need to insure that there be no escalation of Federal deficits or further erosion of the Medicare trust funds. We are confident that the Congress shares the same fiscal concerns and would, therefore, insure that future financing of the improved benefit would remain adequate.

9. Question:

What would the additional cost be to the Medicare program if it were expanded to cover long-term care?

Answer:

This is not a question we addressed directly in the catastrophic illness study, but I can assure you that even a rough calculation will show that it would be a very expensive proposition. Medicare coverage of long-term care expenses would presumably displace virtually all or most of the current out-of-pocket expenses now paid by individuals and their families, in other words, the aggregate of about half of all such costs.

Long-term care expenses for the elderly consist of two major types of expenditures, nursing home costs and home care costs. In 1985, total nursing home expenditures are estimated at \$35.2 billion, of which an estimated 75 percent (\$26.4 billion) was spent on nursing home care for the elderly.

Since about half of nursing home expenses are now paid for by individuals directly out-of-pocket, and an estimated \$1.0 billion was spent by families on home and community services for the chronically ill elderly, the costs of full Medicare coverage begins from a base of an additional \$14.2 billion dollars. Then one must add \$20 billion now contributed by a combination of Federal and State monies through the Medicaid program, realizing that the State contribution would be lost to the program. Finally, one must consider that public financing of long-term care services is likely to lead to significantly greater demand for services, thus higher program costs. In addition to considering the cost of today's program, one must consider that the number of elderly at greatest risk for long-term care services, those over age 85, are the fastest growing segment of the population. When all these elements are considered together, it is easy to see that with cumulative budget deficits at astronomical levels, a program funded by Medicare is not feasible. We believe it is far more practical to work on educating the public as to future risk,

deficits at astronomical levels, a program funded by Medicare is not feasible. The Administration believes it is far more practical to work on educating the public as to future risk, to encourage innovative insurance plans in the private sector, and to encourage families to save, plan, and obtain financial protection well before a catastrophic illness strikes.

10. **Question:**

What additional premium would be necessary if your proposal were expanded to cover long-term care?

Answer:

We did not address this question in the Department's Catastrophic Illness Study because we believe that long-term care expenses are appropriately addressed with private sector solutions, such as incentives for better insurance protection, individual savings, and planning for long-term care services. As I indicated previously, the costs are enormous and growing rapidly, so presumably a premium for long-term care coverage would be substantial.

11. **Question:**

Specifically, what are your objections to the Health Care Savings Account bill introduced by myself, Congressman Slaughter and Congressman Dreier during the 99th Congress (H.R. 3505), which is designed to solve the long-term insolvency problem of Medicare while providing savings incentives so that individuals can afford to pay for both acute catastrophic and long-term care?

Answer:

The Administration believes that we must stimulate the private sector insurance industry to develop and market more affordable long-term care policies. I am certainly encouraged that the President, on February 12, directed the Department of Treasury to study:

- o encouraging personal savings for long-term care through a tax-favored individual medical account (IMA) combined with insurance, and amending individual retirement account (IRA) provisions to permit tax-advantaged withdrawal of funds for long-term care expenses; and
- o the feasibility of an alternative program of health care savings accounts used to buy basic post retirement health insurance.

I am anxious to see the results of this study, and want to work with you to continue to find ways to address the problems associated with long-term care expenses.

Mr. GRADISON. Mr. Secretary, I do have a brief question. At the conclusion of the last Congress, the House and Senate came very close, as you know, to passing the so-called Medicare and Medicaid fraud and abuse bill, which would give the Department more tools in dealing with bad providers, doctors and hospitals. The bill was originally developed with the guidance of your Department, and we couldn't have asked you to be more supportive of that bill right along.

I plan to reintroduce last year's bill incorporating all of the changes which I am aware of that were considered on the House side, the Senate side, and the proposals that came from the administration. I would simply like to indicate that we would very much appreciate your cooperation and support this year, as you gave us last year, in trying to guide this legislation through the process.

Secretary BOWEN. We did support the bill that you and your committee developed last year. I believe that our inspector general of our Department gave some advice on it, and we would intend to support it again.

Mr. GRADISON. Thank you, Mr. Chairman.

Thank you, Mr. Secretary.

Mr. DONNELLY. Mr. Secretary, let me at the outset congratulate you for bringing this issue to the forefront. As I remember, from the day you were selected as Secretary to replace Mrs. Heckler, you stated there was a need in this country for catastrophic health insurance coverage. Of course, there are some of us that don't feel your plan goes far enough. But you have done a service to this nation by articulating the need.

Let me see if I understand the numbers here. Of the 28 million Medicare beneficiaries, you said that 1.2 million beneficiaries, would be covered by your proposal; is that correct?

Secretary BOWEN. 1.2 million would have expenses beyond the \$2,000 per year.

Mr. DONNELLY. Then that would leave an additional several million people in long-term care facilities that would not be covered by your proposal?

Secretary BOWEN. I think you are confusing our two reports. We are not covering any long-term care under our acute care proposal.

Mr. DONNELLY. I understand that. I want to make sure that is on the record.

Have you done any analysis of the 1.2 million that would be covered, what percentage of those might not fully recover from their acute care illness and then have to be institutionalized or placed in institutions that would then have to come out of either their personal payment of private insurance or become eligible for Medicaid?

Secretary BOWEN. I don't recall any figures. No, we can attempt to—

Mr. DONNELLY. I guess the criticism that I have is that your plan works well for those that will either get well or die, but if you have long-term, institutionalized needs, then it is still a catastrophic illness.

Secretary BOWEN. It goes from one of the categories to the other.

Mr. DONNELLY. You can give me short-term insurance against catastrophic medical bills. But, if I don't die, and I don't get well

and go home, then the catastrophic coverage is an enormous gap because then I either lose everything if I don't have personal insurance—and most people in America don't have personal insurance—would you say 700,000 of the long-term care patients are medicaid-eligible? Is that a correct figure, Mr. Burke?

Mr. BURKE. What was the number again, sir?

Mr. DONNELLY. 700,000.

Mr. BURKE. 500,000 spend down to the Medicaid level.

Mr. DONNELLY. 1.1 percent of them have private insurance; is that correct?

Mr. BURKE. 1.7 percent of nursing home care is now covered by private insurance. However, if the acute catastrophic feature were enacted and the need for medigap was considered less pressing by a lot of people, these resources could be freed up to purchase long-term care insurance, which we hope would come on line.

Mr. DONNELLY. I congratulate you, Mr. Secretary. I think that an issue that is going to be strongly spoken about in this committee is the potential of a needs test for this types of program.

I will make one criticism for the record on the IMA proposal. The problem with IMA's, and the same with IRA's, is the fact that it is the wealthiest people in our society that are greatest beneficiaries of those types of programs. If you are an average American, have four children, and work in a mill, the only asset you really have is your home. You attempt to put aside a few dollars to pay for the education of your children. Those people who don't have the money to buy either long-term insurance for themselves, certainly don't have the money to invest in an IRA or an IMA.

I just don't think that that is the type of proposal that this committee ought to endorse. We ought to go more toward needs testing, and it is critical that we take a long, close look at those 1.4 million people who receive no coverage under the plan.

If I could just reiterate my question, if you could do an analysis, or if there has been an analysis done, of the percentage of people who would be covered under your plan that potentially would not get well and require additional care, who would then fall into the second catastrophic, long-term care situation, if it is possible, I would like to see it.

Mr. Dorgan?

Mr. DORGAN. Mr. Secretary, I was unfortunately unable to hear most of your testimony today, and therefore I am going to yield my time to Mr. Stark.

But I want to echo the words of Mr. Donnelly. I think you have done a great service by raising this issue, and I want to say I think Mr. Gradison has also raised an important point. We need to decide in the long term where this road leads us. Some of us have an idea where we ought to head with the catastrophic insurance or catastrophic illness programs. Mr. Gradison's points are points I hope you would consider.

But, because I missed most of your presentation—and I assure you I will read your presentation—let me yield my time to Mr. Stark.

Chairman STARK. I think all of the members inquired, and I would, before I thank you, Mr. Secretary, like to ask if your staff would be good enough to share with us what I understand are volu-

minous background reports and statistical reports, both that were done internally and contracted out in preparation for your report to the President. They would help us in preparing our legislation, and we would appreciate it if you could make copies of that available to us.

Secretary BOWEN. Dr. Docksai will work with your staff to supply anything that you need, plus my staff are available for briefings at any time that you want.

Chairman STARK. I appreciate that.

Mr. Coyne?

Mr. COYNE. Mr. Chairman, I have one question before Dr. Bowen leaves.

Earlier in testimony you indicated there were reasonable differences with people in different departments in the administration. I was just wondering if you are in a position today to allow us to know what some of those differences might be.

Secretary BOWEN. Well, the differences were, No. 1, the danger of removing something from the private sector and replacing it with the public sector. No. 2, whether or not the \$4.92 was actuarially sound. And, No. 3, whether we could be assured that it would be budget-neutral and that cost wouldn't continue to go up, and whether or not there would be increased utilization. Those are the main differences.

Mr. COYNE. That seems to be the holdup at this point, as to whether the bill will be brought up in 2 or 3 weeks, or shortly, or soon.

Secretary BOWEN. Yes.

Mr. COYNE. Thank you.

Chairman STARK. Thank you very much, Dr. Bowen, Mr. Burke, Mr. Docksai. We appreciate your being here with us today and look forward to working with you in the months ahead as we try and put together a proposal. And, with a little bit of luck, we may find that our proposals merge into a catastrophic coverage that will benefit all Americans.

I look forward to working with you and your staff, and our staff looks forward to it, in the months ahead.

Thank you again very much for an informative morning.

The committee stands adjourned.

[Whereupon, at 11:30 a.m., the committee and subcommittee adjourned, subject to the call of the Chair.]

CATASTROPHIC COVERAGE UNDER MEDICARE

TUESDAY, MARCH 3, 1987

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:30 a.m., in room B-318, Rayburn House Office Building, Hon. Fortney H. (Pete) Stark (chairman of the subcommittee) presiding.

Chairman STARK. The Health Subcommittee of the Ways and Means Committee will begin the hearing to receive testimony from members on catastrophic coverage under the Medicare program. We will hear from members of the Ways and Means Committee and other Members of the House on what they perceive to be the catastrophic problems and the suggestions they may have to guide us as we proceed in this legislative area.

I believe I was going to recognize a distinguished member of the subcommittee, but in recognition of a brilliant intellectual feat, that is, getting to work on time, I would be honored to recognize our colleague, Mr. Crane of Illinois.

Mr. DAUB. Excuse me, Mr. Chairman.

Chairman STARK. Mr. Daub.

Mr. DAUB. He is always working.

Chairman STARK. He is always working. I see. He just got to the office building to work.

Phil, your prepared testimony will be made part of the record. Please proceed in any manner you are comfortable.

STATEMENT OF HON. PHILIP M. CRANE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. CRANE. Thank you very much, Mr. Chairman.

I appreciate this opportunity to testify before the Subcommittee on Health on what to me are some of the problems, in the health care field, but which the administration's proposals do not address satisfactorily. I think, frankly, that the subcommittee's proposals go beyond what the administration has contemplated, and there are a number of reasons why I harbor reservations about the approach we are taking.

The original estimated costs of the Medicare program at the time of its inception, for the projected costs over the next decade or two, turned out to be several thousand percentage points below the actual costs. Looking ahead to the 1990's, we are facing a crisis in Medicare health care funding. While there are divisions as to the estimated terminal date of the adequacy of funding for that pro-

gram, I think we can safely assume that some time before the end of this century the program will be bankrupt without rather significant increases in the tax payments that go to the support of the Medicare program.

When we look at the acute catastrophic problem, we are discussing hospital costs incurred by the patient from a long-term hospital stay, and not for a long-term stay at a nursing home. Of the 29 million aged Medicare beneficiaries, only 12,000 of these beneficiaries can ever expect to exhaust Medicare's hospital coverage after 150 days.

When one considers that about 65 percent of the Medicare beneficiaries purchase Medigap policies which cover Medicare's deductibles and the co-insurance charges, along with often providing protection against the cost of hospital stays exceeding Medicare's coverage limits, this 12,000 of the Medicare population faced with truly catastrophic acute care costs is greatly reduced.

The type of catastrophic care costs most likely to be faced by the elderly is that of long-term care, such as a prolonged stay in a nursing home. That is an issue which neither the administration's proposal nor the subcommittee's proposals are addressing. Of the 29 million elderly population, 1.4 million, or about 5 percent, are in nursing homes at any one time. Of this 5 percent of the elderly population, the vast majority needing long-term care are aged 85 or older. Only one out of five individuals will need nursing home care over the age of 85, while of those between the ages of 65 and 75 only 1 percent will enter a nursing home.

While Medicare covered only 2 percent of the nursing home expenses of the elderly in 1984, I think that there are a number of private sector alternatives—and I will defer to my colleague, French Slaughter—that simultaneously address the question of acute care and long-term care, without calling for catastrophic coverage expansion of government entitlement programs.

One of the things I think we should bear in mind is that Medicaid really provides ultimate care for those who are not in a position to provide for themselves. However, Medicaid requires a person be impoverished, or become impoverished, as might happen to a surviving spouse, due to her trying to provide for a loved one in his terminal illness. One way to reduce the level of impoverishment, we might contemplate expanding the amount of property and income that one could maintain and still be eligible to qualify for Medicaid benefits.

I simply throw this out as one idea which should be considered. I had the opportunity in 1975 to participate in a symposium in London that was sponsored by the American Association of Physicians and Surgeons. At this symposium, we met with government officials and we met with British physicians. And while they advertise a free health service to one and all in that country, there are qualifications to that free health service.

The fact is, at that time, there had been between 600,000 and 700,000 people diagnosed as needing surgery who were on waiting lists. I talked to this one physician regarding the various classifications for admission into hospitals—emergency, early and when convenient. I asked, "What is the distinction between early and when convenient?" He explained to me that when convenient was elec-

tive surgery, and early was something more serious. And if, for example, you just wanted a simple hernia operation, the waiting time in London was 18 to 22 months. And if you lived in rural England, I was informed that the waiting period could be up to 5 years.

At the time we were there, a woman diagnosed as needing heart surgery died. The London papers carried this event. She had been diagnosed as needing heart surgery. They put her on a waiting list. Nine months later, she went in for the operation. They apologized and said they did not have bed space and facilities for her, and they would have to move her up another 3 months, which they did. At that time they did not have the heart surgeons available, so they moved her back yet another 6 weeks. They had the decency to call her the day before her third appointment because they were going to have to move her back yet another time. She died at home on the day of her third appointment.

So there obviously is a time when a when-convenient becomes an early becomes an emergency. They have actually created an ombudsman in the British National Health Service to deal with these kinds of problems because of their recurring nature.

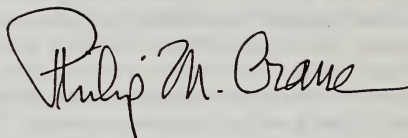
Rationing health service is one of the ways in which the British preserve the fiction of the availability to one and all of health care. The other is the deterioration of quality. At the time we were there, EMI was the sole manufacturer of CAT scanners. The CAT scanner at that time, as I recall, ran about \$300,000 to \$400,000. The fact of the matter is American hospitals had already purchased 90 and had over 100 on order. For the entire British National Health Service, only one had been purchased. It was located in London and none were on order.

So based on the British experience of the deterioration of quality and the rationing of service, we have some rather explicit examples of the path down which we might soon embark. I think the administration proposal and the Stark/Gradison bill before us might bring about some of the worrisome aspects of going through the public sector as a means of dealing with the problem. Instead we should then be putting on our thinking hats and trying to come up with some more creative ideas. Maybe part of that is tax incentives. Certainly, I think a part of it clearly is the medical IRA that French Slaughter and David Drier will comment upon later.

I would urge the committee not to rush judgment on the solution of a problem that could have the eventual consequence of putting into jeopardy the entire Medicare program. We all know the history of how we are inclined to deal with the necessity of increased costs and increased service when there are dollar figures. For example, the Congress has, at least in the past, been ill inclined to make adjustments for inflation with regard to anything that smacks of increasing the tax burden on participants in the program. That further complicates our problems as we look to the 1990s and the expectation of the bankruptcy of the health insurance fund.

With that, Mr. Chairman, I would ask unanimous consent to submit a complete statement for the record. I know that you are on tight time constraints, and I happily yield to my colleagues to elaborate further on the proposal Congressman Slaughter.

[The prepared statement follows:]



Testimony of Congressman Philip M. Crane
Before the Ways and Means Subcommittee on Health
Hearing on Catastrophic Coverage under Medicare

March 3, 1987

Mr. Chairman, I thank you for providing me with the opportunity to appear before your Subcommittee on Health in order to present my views in regards to catastrophic coverage under Medicare. I urge your Subcommittee to move swiftly to meet the challenge of finding a way to expand the ability of both those over age 65 and those individuals below the age of 65 to obtain coverage for both acute and long-term catastrophic care. Although a prolonged stay in the hospital can be financially debilitating for any under-insured individual who exceeds the coverage limits of Medicare, the problem which our elderly are more likely to face is that of long-term care. However, when considering the expansion of the Medicare program as the means to provide catastrophic coverage to the elderly, my colleagues should carefully weigh how this expansion will effect both the security of the Medicare trust funds and the quality of service under Medicare. I strongly urge my colleagues not to ignore private sector solutions to the problem of both long-term and acute care.

When we discuss catastrophic care coverage, we do ourselves well to recall the number of Medicare beneficiaries who experience such costs. When we discuss acute catastrophic care, we are discussing hospital costs incurred by the patient from a long-term hospital stay. Of the 29 million aged Medicare beneficiaries, only 12,000, or 0.04% of these beneficiaries can ever expect to exhaust Medicare's hospital coverage after 150

days. When one considers that about 65% of the Medicare beneficiaries purchase medigap policies which cover Medicare's deductibles and coinsurance charges, along with often providing protection against the costs of hospital stays exceeding Medicare's coverage limits, this 0.04% of the Medicare population faced with truly catastrophic acute care costs is greatly reduced.

The type of catastrophic care costs more likely to be faced by the elderly is that of long-term care, an issue which neither the Administration nor the Chairman and Mr. Gradison's proposals address. Of the 29 million elderly population, 1.4 million, or about 5%, are in nursing homes at any one time. Of this 5% of the elderly population, the vast majority needing long-term care are aged 85 or older; only one out of five individuals will need nursing home care over the age of 85, while, of those between the ages of 65 and 74, only 1% will enter a nursing home.

Medicare covered only 2 percent of the nursing home expenses of the elderly in 1984. The Federal-State Medicaid program, which requires impoverishment to welfare levels in order to gain eligibility, picked up an additional 42 percent. And 50% of all nursing home expenditures for the elderly were paid for out-of-pocket.

Mr. Chairman, as you and your Subcommittee address the catastrophic coverage problem, I caution you to consider the impact which legislation might have on the financial condition of the Medicare trust funds and urge you to avoid legislation which will increase the socialization of medical care. I would also like to suggest a number of private sector alternatives which I hope you might consider, especially the Health Care Savings Account legislation introduced by my esteemed colleagues Congressman French Slaughter, Congressman David Dreier, and myself.

When debating the expansion of the Medicare program to include catastrophic coverage, I urge my colleagues to fully consider what impact this expansion will have on the Medicare trust funds. Any proposal, no matter how well intended, should not increase the burden on the system, because that would jeopardize the future availability of benefits currently being offered by the program. Instead, the Subcommittee should consider how its catastrophic care proposal might, in fact, decrease the burden on the system through increased involvement of the private sector in the offering of coverage of medical care.

Within the next few years, this Committee will be faced with a financing crisis of the Medicare system which pales in significance to the one we faced for Social Security back in 1983. Based on the 1986 Medicare Trustees' Report, the Hospital Insurance (HI) trust fund, as it is now scheduled, will be paying out more than it takes in beginning in 1991. By 1995, it is estimated that the Medicare HI program will be operating at a \$400 million deficit. Under the most widely cited intermediate assumptions (alternative II-B), the HI trust fund will be exhausted--unable to pay promised benefits--by 1996. I would like to note that this projection by the Trustees is more serious than their 1985 report in which they predicted the exhaustion of the HI funds by 1998. Under these assumptions, and based on the trend of decreasing funds, it is reasonable to assume that this year's report, due out shortly, will predict the depletion of funds as early as 1994, less than 10 years from now.

I urge my colleagues to move cautiously as they consider ways to increase the availability of catastrophic care coverage, lest the attempt to secure important medical coverage for the few jeopardize the medical coverage for the many.

Both the Administration's proposal and the proposal of the distinguished chairman of this subcommittee and ranking member attempt to design their expansions of the Medicare program to have financing mechanisms which cover all the costs of the program. Neither of these plans, however, include provisions which would actually reduce the burdens currently being faced by the Medicare program. In addition, while I prefer that any proposal be entirely voluntary and be funded solely by the the program's participants, I question whether either proposal meets these requirements.

I do not believe that the Administration's proposal will remain budget neutral, as HHS claims, given Congress' propensity to hold down automatic inflation increases of the out-of-pocket expenses incurred upon the elderly. HHS suggests that this Medicare expansion plan will be deficit neutral, with premiums from the elderly covering the increased costs. This statement is naive because, over time, it will be extremely difficult, if not impossible, for Congress to allow the premiums to be raised to cover the additional costs of the program. Indeed, the most recent experience with the Part A deductible, which Congress held down to \$520, instead of allowing it to rise to the level required to cover the increase in program costs, illustrates my point. In addition, CBO reports that the \$4.92 increase in the Part B premium which is used to fund the Administration's proposal will rise to \$6.40 in 1988. The reaction of my colleagues to this dramatic rise is further evidence that Congress will not allow the funding mechanism of the Administration's proposal to self-fund this Medicare expansion program. Furthermore, how will Congress react when that \$2,000 out-of-pocket cap is scheduled to rise, for example, to \$2100? Certainly, Congress will insist that raised premiums and out-of-pocket caps be held down, only further quickening the arrival of the bankruptcy of Medicare.

While I applaud the Administration's effort to have its plan funded by the program's participants, I question whether the program is truly voluntary. Instead of adding a separate acute catastrophic care Medicare program for which individuals are free to choose to pay an additional premium to obtain this coverage, the proposal adds the acute catastrophic coverage to the benefits under Medicare Part B, and increases the Part B premium accordingly. This proposal is voluntary in that the Part B program is voluntary. However, in that the 97% of the Medicare beneficiaries who choose to join Part B are forced to accept the catastrophic coverage, the voluntary aspect of the proposal comes into question.

The Stark/Gradison approach is totally involuntary, since it is a new entitlement program. The elderly do not have a choice as to whether they wish to be eligible to receive acute catastrophic coverage, since all Medicare beneficiaries would be entitled to receive coverage for out-of-pocket expenses for acute care beyond \$1709. This new entitlement program would be funded by a tax increase on the elderly. The funding mechanism is a tax on the actuarial value of the federal subsidy of Part A and Part B benefits. This tax would apply to about 10 million of the elderly. Since the actuarial value is \$1770, this amount would be added to the adjusted gross income of the elderly. Thus, those individuals in the new 15% tax bracket would be paying \$265.50 for this program while those taxpayers in the new 28% bracket would be paying a \$495.60 tax increase and those in the 33% bracket would experience a \$584.10 tax increase, regardless of whether or not they wished to participate. In addition, those individuals who do not earn enough income to pay the tax on the additional \$1770 would be entitled to the new Medicare benefits without contributing to the program. Before my colleagues agree to this proposal, I would hope that they carefully consider whether they wish to levy this tax increase on the elderly, start a new entitlement program, and use general revenues to fund the Medicare program.

Both the Administration's proposal and the Stark/Gradison bill would bring us further down the road of socialized medicine, since they replace much of what the private sector is providing with a new government spending program. I strongly urge my colleagues to search for an alternative in which the private sector can play a greater role so that we can avoid the problems of decreased quality of care, the rationing of health care, and the overburdening of the federal treasury which socialized medicine inevitably brings. Let me provide you of a few examples of the problems of socialized medicine.

The National Health Care System of Great Britain is an excellent example of what might occur should we accelerate the socialization of medicine through the two proposals under debate. This system was created to cover the cost of medical services in Great Britain. However, since its creation, over 50% of the British trained physicians have left the system, only to be replaced by less than qualified physicians from the commonwealth. The system is government operated and therefore has demonstrated no continuity in patient care. The system costs the government at least 5% of the GNP and is partially funded by a payroll tax. The enormous demands placed on the system by this entitlement program have created many problems that directly affect the citizens. For example, for a routine medical problem, the system may present little troubles. However, for any symptom beyond minor, dangers to the patient's life exist. Presently there are over 700,000 patients on the urgent non-elective surgery list. Physicians claim many of these will die before they are even scheduled for an appointment. The Government has had to take sides in life and death situations. For example, no person over the age of 55 will be permitted to be treated on a kidney dialysis machine. In addition, the system is delinquent in updating its medical technology and is also inadequate in operating its present facilities.

Another example of socialized health already in this country is the hospital care provided to our veterans by the Veterans' Administration. Congressional offices constantly are hearing complaints regarding long waiting lists, prioritization of patients, reduced quality of care, and problems with cleanliness as the result of the government-sponsored entitlement program. I suggest that the Subcommittee should consider alternative approaches, rather than follow the sorry example of Great Britain.

There are a number of proposals which I would hope the Subcommittee would consider. For example, my colleagues might consider providing medical insurance vouchers to those few who are unable to afford medigap policies. In addition, my colleagues might consider providing a tax deduction for the amount of money the elderly spend on medigap policies. My colleagues might also consider raising the Medicaid threshold so that the elderly would not be forced to impoverish themselves in order to receive these benefits. The proposal which I prefer is the Health Care Savings Accounts, which the Administration has asked the Treasury Department to study. I will defer to my colleague, Congressman Slaughter, to discuss this proposal.

Chairman STARK. Phil, thank you very much.

Hal Daub, our colleague from Nebraska and member of the subcommittee.

Mr. DAUB. We are tied together, Mr. Chairman. Do I understand correctly?

Chairman STARK. Are you distancing yourself here? You want us to save the best for last, is that it?

Mr. DAUB. No, you are being very kind, but I do think, if I might say—and I am happy to yield—they intended the three of them to be together on their idea.

Chairman STARK. Okay. I would be happy at this point to recognize the Honorable French Slaughter from Virginia and Dave Dreier, our distinguished colleague from California.

You may proceed in any manner you are comfortable. Your full statements will appear in the record. Proceed. Welcome to the committee.

**STATEMENT OF HON. D. FRENCH SLAUGHTER, JR., A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA**

Mr. SLAUGHTER. Thank you, Mr. Chairman.

This bill, H.R. 955, creates a health care savings account somewhat similar to the IRAs to finance health care expenses and retirement. I just want to emphasize a few points that relate to catastrophic illness coverage. The bill provides that those using the health care savings account will get catastrophic illness coverage from Medicare.

Now, No. 1, that makes the Medicare system sounder. The revenues will continue at the present level from payroll taxes, and over time the claims will decrease as we pick up larger numbers of health care savings account holders who retire. Therefore, Medicare will be better able to finance catastrophic illness coverage without an increase in taxes or a reduction in benefits or both.

Secondly, the health care savings account funds can be used for the purchase of insurance to cover long-term care which is beginning to be offered by insurance companies. Their interest in the health care savings account, for that reason, is creating a market for long-term care insurance.

H.R. 955 is a part of the answer to the problems we face. It is a long-term measure, but we need to act now to avoid the Medicare financing crisis that is just a few years off.

Mr. Chairman, I would be glad to answer any questions, but I know the time is brief. I would yield to Mr. Dreier.

[The prepared statement follows:]

TESTIMONY BY D. FRENCH SLAUGHTER, Jr., BEFORE THE WAYS AND
MEANS SUBCOMMITTEE ON HEALTH

MARCH 3, 1987

HEALTH CARE SAVINGS ACCOUNT ACT OF 1987

Mr. Chairman, members of the Subcommittee, it is a pleasure to speak before you concerning catastrophic health care. As you are aware, the President recently submitted his proposal to protect most elderly Americans from the high costs associated with a catastrophic illness requiring hospitalization; this is certainly a very worthy objective.

However, there are other issues of serious concern to the elderly which we also need to consider at this time.

The first issue is long term care, the cost and need for which is skyrocketing. Within 25 years, an estimated 50 million Americans will need nursing home care--five times the number today. Our elderly will need increased resources--and the opportunity to purchase long term care insurance with these resources--in order to afford such care.

The second issue is the impending deficits in the financing of our Medicare system. In their 1986 report, Medicare's trustees predict that the Medicare Hospital Insurance trust funds will begin running a deficit in 1991 and will be exhausted by 1996 under so-called intermediate assumptions. In addition to concentrating on the inadequate benefit structure of Medicare--which is certainly needed--we should also be concentrating on the inadequate funding of Medicare under its current structure. Rather than continuing to increase payroll taxes or reduce benefits to the elderly--or both--to improve the outlook of the trust funds for a year or two, we should reform the system to reduce Medicare's long term liability.

As a potential solution to these problems, my colleagues, Congressmen Phil Crane and Dave Dreier, have joined me in introducing H.R. 955, the Health Care Savings Account Act. We are convinced that the offering of incentives for individuals to save for their health care costs in retirement through the use of Health Care Savings Accounts is the best way to solve these critical problems in the field of health care for the elderly, both now and in the future.

The resources saved in Health Care Savings Accounts would be used in retirement before claims could be made on the scarce Medicare trust funds, while payroll tax revenues would continue to flow into the system at their present rate. This would put our Medicare program on a sound financial basis for the future.

In addition, these resources could be used--either directly or through the purchase of insurance--to cover long term care expenses. Our discussions with representatives of the insurance industry have indicated that such insurance would become much more widely available with the passage of this legislation.

Finally, individuals who contributed to these voluntary accounts over the course of their careers would be provided with protection from the costs associated with a catastrophic illness requiring hospitalization.

The Congress is now examining the Administration's approach to the problem of the costs involved in a catastrophic illness; we believe the provisions of our proposal should be adopted as part of the solution to this and the other problems--both present and future--faced by our elderly in the health care area.

I certainly appreciate this opportunity to testify before you this morning, and I would be happy to answer any questions that you have regarding this proposal.

Thank you.

Chairman STARK. Dave.

**STATEMENT OF HON. DAVID DREIER, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF CALIFORNIA**

Mr. DREIER. Thank you very much, Mr. Chairman. I appreciate the opportunity to be here and to participate with my colleagues.

We know very well that passage of the Tax Reform Act last year saw Government policy shift dramatically away from providing tax incentives to encourage certain behavior.

I have to say that philosophically I am one who does believe that we should not be continually using certain tax patterns to encourage that kind of behavior. But, frankly, Medicare is at a crisis situation right now. We have a 2.9 percent tax, and projections are that by the year 2030 that tax could be as high as 7.2 percent.

I think that we are faced with a serious problem. The idea that French has just outlined is one which I think we need to pursue and we need to look at. I appreciate the fact that your subcommittee is giving us an opportunity to at least outline the option, and I have a full statement, Mr. Chairman, which I ask unanimous consent to have included in the record.

Chairman STARK. Without objection, it will be. I would like to discuss this with you, but I think I will let Hal testify now. Maybe we could discuss this a little bit when we are finished with Hal's testimony.

[The prepared statement follows:]

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Congress of the United States
House of Representatives
Washington, DC 20515

Remarks of the
HON. DAVID DREIER
Before the
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
March 3, 1987

BANKING, FINANCE AND
URBAN AFFAIRS
COMMITTEE

SMALL BUSINESS
COMMITTEE

TASK FORCE ON CRIME

U.S. MEXICO INTERPARLIAMENTARY
CAUCUS

VICE CHAIRMAN
HEALTH AND ENVIRONMENT
TASK FORCE

TASK FORCE ON REGULATORY
REFORM

THANK YOU, MR. CHAIRMAN, FOR THE OPPORTUNITY TO ADDRESS THE COMMITTEE ON THE ISSUE OF LONG-TERM CARE. IT'S NO SECRET THAT THE ADMINISTRATION'S PLAN TO EXPAND MEDICARE TO COVER CATASTROPHIC CARE EXPENSES IS INADEQUATE AS IT NEGLECTS THE MORE SERIOUS ASPECT OF LONG-TERM CARE -- EXPENSIVE NURSING HOME CARE OR HOME CARE FOR THE CHRONICALLY ILL. I STRONGLY BELIEVE THAT THIS IS A VOID THAT MUST BE FILLED IN OUR EFFORTS TO PROTECT ELDERLY AMERICANS FROM THE PHYSICAL AND FINANCIAL CATASTROPHY OF SERIOUS AND CHRONIC ILLNESS.

OF ALL ANNUAL OUT-OF-POCKET EXPENSES INCURRED BY THE ELDERLY, 41.6 PERCENT IS SPENT ON NURSING HOME CARE, AND 31.3 PERCENT ON MISCELLANEOUS HOME CARE. ONLY 5.6 PERCENT GOES FOR HOSPITAL CARE. FIVE PERCENT OF ALL PEOPLE OVER 65 REQUIRE NURSING HOME CARE. FOR EVERY ONE IN A NURSING HOME TODAY, FOUR MORE ARE CARED FOR IN HOMES BY FAMILY AND FRIENDS. THE AVERAGE COST PER YEAR IN A NURSING HOME IS \$22,000.

SOME OF OUR COLLEAGUES ARE PROPOSING TO FILL THE VOID IN LONG-TERM CUSTODIAL CARE BY EXPANDING THE MEDICARE PROGRAM TO PROVIDE UNLIMITED HEALTH CARE COVERAGE. I BELIEVE SUCH A SOLUTION IS BOTH UNWISE AND UNNECESSARY.

ACCORDING TO A RECENT HARVARD STUDY, FOLDING LONG-TERM CARE INTO MEDICARE COULD ADD \$50 BILLION A YEAR TO THE PROGRAM'S \$85 BILLION BUDGET. TO FINANCE A LONG-TERM CARE PROGRAM, A SUBSTANTIAL INCREASE IN THE MEDICARE PAYROLL TAX WOULD BE NECESSARY BECAUSE OF PROJECTED DEFICITS IN BOTH THE MEDICARE TRUST FUND AND IN THE GENERAL TREASURY. SUCH A TAX INCREASE WOULD BE DEVASTATING TO TODAY'S WORKERS AND TO THE MEDICARE SYSTEM AS A WHOLE.

UNDER PRESENT ECONOMIC ASSUMPTIONS, IT IS ESTIMATED THAT, BY THE YEAR 2030, PAYROLL TAXES WILL HAVE TO BE RAISED FROM THEIR CURRENT 2.9 PERCENT TO AS MUCH AS 7.2 PERCENT JUST TO COVER MEDICARE'S PROJECTED COSTS. THIS ANTICIPATED DEMAND ON MEDICARE WILL SEVERELY ERODE ITS REVENUE BASE, AND ANY FURTHER BURDEN IS SURE TO SEND THE SYSTEM INTO FINANCIAL COLLAPSE.

AS A RESULT, I BELIEVE CONGRESS SHOULD TURN TO THE PRIVATE INSURANCE MARKET FOR A SOLUTION, WHERE PROGRESS IS ALREADY BEING MADE IN THE DEVELOPMENT OF LONG-TERM CARE POLICIES. IN MARYLAND, FOR INSTANCE, AT LEAST SIX DIFFERENT INSURANCE COMPANIES OFFER LONG-TERM CARE POLICIES WHICH PROVIDE BENEFITS OF UP TO \$116,000 OVER FOUR YEARS FOR SKILLED NURSING HOME CARE. OVER TIME, THESE PLANS ARE SURE TO GROW IN NUMBER, AND IN THE PRODUCTS AND SERVICES OFFERED. IN MY VIEW, BRINGING LONG-TERM CARE INTO THE MEDICARE SYSTEM WOULD MERELY DUPLICATE, AND CONSEQUENTLY WIPE OUT, WHAT IS SURE TO BECOME AN EFFICIENT, COMPETITIVE, AND COST-EFFECTIVE MARKET.

CONGRESS SHOULD BE ENCOURAGING, NOT DISCOURAGING, A MARKET SOLUTION TO THIS SERIOUS AND GROWING PROBLEM. ONE METHOD THAT HOLDS GREAT POTENTIAL INVOLVES THE CREATION OF TAX-FAVORED INVESTMENT VEHICLES TO PROMOTE PRIVATE FINANCING OF HEALTH CARE EXPENSES UPON RETIREMENT. SUCH A PROGRAM IS OUTLINED IN H.R. 955, THE HEALTH CARE SAVINGS ACCOUNT ACT.

ALTHOUGH H.R. 955 SEEKS TO ADDRESS THE MANY PITFALLS OF THE MEDICARE SYSTEM, IT PROVIDES AN IMMEDIATE STRUCTURE THAT CAN BE USED TO ADDRESS THE LONG-TERM CARE ISSUE AT VERY LITTLE COST TO THE FEDERAL GOVERNMENT. AS ENVISIONED, SUCH A PROGRAM WOULD ALLOW WORKERS AND THEIR EMPLOYERS TO CONTRIBUTE FUNDS TO A HEALTH PENSION AND RECEIVE SPECIAL TAX TREATMENT FOR SUCH CONTRIBUTIONS. UPON RETIREMENT, THE ACCUMULATED FUNDS COULD BE USED TO FINANCE NURSING HOME CARE, OR TO PURCHASE LONG-TERM CARE INSURANCE.

UNTIL NOW, THE MARKET FOR LONG-TERM CARE POLICIES HAS SLOWLY DEVELOPED BECAUSE OF ACTUARIAL PROBLEMS. BUT THE MULTI-BILLION DOLLAR POOL OF FUNDS THAT WOULD ACCUMULATE IN A HEALTH PENSION WOULD SOLVE THAT PROBLEM. INDIVIDUALS WHO CHOOSE NOT TO CONTRIBUTE WOULD ALSO BENEFIT BECAUSE THEY, TOO, WOULD HAVE ACCESS TO AFFORDABLE LONG-TERM CARE POLICIES THAT ARE SURE TO BE DEVELOPED.

MR. CHAIRMAN, LOOKING AT THE MAGNITUDE OF THE PROBLEM, I THINK IT'S FAIR TO CONCLUDE THAT GOVERNMENT PROGRAMS ALONE CANNOT COMPLETELY SHELTER A MAJORITY OF AMERICANS FROM THE FINANCIAL DRAIN OF LONG-TERM CARE. AS A RESULT, I FEEL THAT ANY FUTURE SOLUTION SHOULD BE BALANCED WITH INCENTIVES FOR INDIVIDUALS TO BUILD THEIR OWN RESOURCES TO PROTECT THEM AGAINST THE PROSPECT OF FINANCIAL AND MEDICAL CATASTROPHY.

**STATEMENT OF HON. HAL DAUB, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF NEBRASKA**

Mr. DAUB. Mr. Chairman, thank you very much. I want to spend a few minutes in presenting to you what amounts to five pages of formal testimony, which you have in front of you. I'll do that to set a stage so that all may focus on what I offer as an alternative approach to the problems that this subcommittee is addressing—a subcommittee on which I am pleased to serve with you and with our able vice chairman, Mr. Gradison. I appreciate the opportunity to testify.

Catastrophic health insurance protection is an important issue. I want to comment briefly on both the Reagan-Bowen plan and the Stark-Gradison initiatives, and then proceed to highlight provisions of legislation that I will be introducing. I think we will have it ready by the end of this week.

As I have indicated in our previous hearing on Medicare catastrophic, I certainly commend the President and Health and Human Services Secretary, Otis Bowen, for their leadership and efforts in heightening the Nation's interest in this issue. The time has come for Congress to reexamine the Medicare program and to address the changing needs of our senior citizens.

I am very concerned, however, that we are about to take very limited action in the acute illness area and miss the opportunity to take action on what I consider to be the real risks that most senior citizens face in a truly catastrophic illness. Under both the Reagan and the Stark-Gradison proposals, approximately 5 to 8 percent of Medicare's 30 million elderly would benefit from the part A and part B expansions.

In order to assist this small percentage of potential beneficiaries, the Reagan plan adds on to their current Medicare part B premiums an additional \$4.92 per month. Actually, the Congressional Budget Office has already indicated that in order to remain budget neutral Congress would have to increase the monthly premium add-on by \$6.40 to be effective in the year 1988, as Bill Gradison pointed out during the Secretary's testimony. This amount will have to be indexed annually for inflation.

In contrast, the Stark-Gradison legislation finances the expanded acute care coverage by taxing the actuarial value of the combined Medicare benefits. In my view, this income-related proposal is more attractive due to its progressivity, but clearly it is a direct tax increase for our elderly. As you have noted, Mr. Chairman, those seniors in the 15-percent tax bracket will pay an additional \$265 in taxes next year, and those in the 28-percent bracket will owe an extra \$495 per year.

Once again, Mr. Chairman, I truly believe that we are missing the real and critical needs of our growing elderly population. Rather than financing a \$10 billion program for the benefit of less than 10 percent of our Medicare population, our money would be better spent on assisting the nearly 500,000 individuals who annually will have to deplete all their assets or spend down in order to qualify for adequate health care services.

In testimony before our subcommittee, the American Association of Retired Persons indicated that:

The greatest deficiency in the present health care system is the lack of a long-term care system encompassing medical, social and personal care services provided in a variety of community, home-based, and noninstitutional settings.

I have drafted legislation which addresses these very critical long-term care needs for our elderly population, and which offers incentives to the working age population for developing their own long-term care protection. I have attempted to create a balance in my legislation by incorporating a combination of governmental, individual and employer incentives for addressing the issue of long-term care.

My legislation has three major titles:

One provision of the bill creates a new part C of the Medicare program to offer financial assistance for nursing home and home health and community-based services that the elderly need for long periods of time. First, I establish a floating cap on out-of-pocket liability set between 10 and moving upward—11, 12, 13, 14—to \$15,000. I say a floating cap because it is income-related—that is, the amount of an individual's out-of-pocket expense is related to his or her income level. Second, the benefit could be potentially costly, and in terms of public policy, we should be saying, "If you can afford to pay a little more, we will make you do so, but we will not make you go broke in order to afford quality health care."

The second provision of my bill would provide for group incentives for long-term care catastrophic protection. Currently, employers offer health, life and casualty protection very inexpensively to employees on a group basis. That is in their work-related settings, by and large, and below age 65. However, a current provision in the law prevents them from prefunding a future health benefit plan for their employees once they have retired. My bill would remove the barriers in the law and allow employers to apportion part of their current aggregate contribution to both an employee's defined retiree benefit and a long-term health care policy. Thus, at retirement, the employee would not only have a sound pension income, but a valuable long-term care policy.

Finally, I provide incentives for the individual to begin to save for his or her long-term health care needs. My bill allows an individual over the age of 50 to contribute up to \$1,500 of noncore, interest income toward the purchase of a qualified, long-term care policy. As an added incentive, this policy would retain a cash surrender value, so that should the individual predecease the use of the policy, its value would roll over into his or her estate and could be transferred to a spouse or surviving beneficiary.

The definition of catastrophic illness alone can be interpreted differently by each of us, depending upon where we are, I guess, on the age spectrum. This Congress has a real opportunity to address some very crucial health care policies, and I want to read from a letter I received a couple of weeks ago—in fact, February 6, 1987—from a constituent of mine. Her name is Hazel Webber. She lives in Omaha, Neb. She talks about a few other things and then says:

I know Congressman Daub is working on this long-term rest-home-care problem. My husband Lester had a stroke and has been at Hill Haven Nursing Home for 3 years, and I do not know whether I can hold out financially much longer. When will there be some relief in this area? I read in the paper where the Government might tack on an additional \$4 or \$5 and give us this additional insurance. Are you in

favor of this? How long would it take to put something like this into effect? I might be able to hold out for another year, but that's about all.

Finally, Mr. Chairman, as I think about this, I think whatever we do—and our colleagues who come here to testify on this same panel have some very constructive points and some very constructive ideas—whatever we do, we had better make certain that we educate beneficiaries on what we are going to call catastrophic, so that we do not have any misunderstandings when we get done.

I think the chairman's approach, with the vice chairman, the Stark-Gradison proposal, has much to commend it, as I said, particularly in terms of how we try to pay for what we might end up trying to do. But I think that the sea might turn bloody red if we were trying to raise everybody's cost of health care under current definition, only paying for a very few. Now, if we were trying to raise the premium to 35 percent, or if we were trying to raise the copayments and the deductibles, we would not be getting very far with that undertaking right now.

So I suggest that while we think about paying for some more currently defined part A and B services without truly expanding coverage, we might want to take that same cost that we are asking everybody to pay and provide for that continuum of long-term health care problem that we really know is catastrophic: While we cover for the hospital and the doctor, the frail and elderly in the community who are perhaps not sick or ill, but just old, have other long-term needs, be they nursing home or home assistant or home-bound care or what else.

Certainly, we are going to make progress this year, and I do not know if we can really claim victory on this issue if we fail to address the truly long-term needs of our elderly.

Thank you, Mr. Chairman.

Chairman STARK. I want to thank the witnesses and suggest to them that they may be surprised to find that certainly the chairman shares their concerns and would welcome the opportunity to find a way to facilitate the legislation that they have in mind. While I will let my distinguished ranking member speak for himself, I would be surprised if he, too, did not share and perhaps is more concerned with this area.

The first thing, the worst thing about the Stark-Gradison proposal, in my opinion is its title. It does by its very name——

Mr. GRADISON. You prefer Gradison-Stark? [Laughter.]

Chairman STARK. It does hold out, I think, all kinds of false hopes. It is merely a modest expansion of the Medicare benefits, and it establishes somewhat of a progressive way of paying for it. That is all it is. I have the idea that what you suggested, Hal, does concern me.

Secondly, what you all, if I may lump you together here, really want is pretty easy to define. There is no quarrel, and I wish that Senator Pepper was here with us this morning. He is going to testify tomorrow morning, with H.R. 65. Let me just throw out his plan. He is saying that we can ensure the things you want to protect against for approximately \$50 a month on everybody. That is about \$18 billion a year, \$600 a year times 30 million. Where are a lot of these poor people going to get \$600, I do not know, but his plan

says pay for—and I think if we covered these benefits, all of you would sign on with me.

What are we going to pay for? We are going to pay for part A and B which we now have, pharmaceuticals, appliances—whether they are teeth, eyeglasses, canes or whatever—and some kind of long-term care, or home health care for people who, one, are sick and, two, are unable to function. They may not be sick, but they just cannot, like Phil and myself, bend over to tie our shoes in the morning and need some help just living each day.

That is going to cost maybe a maximum of \$40,000 a year down to maybe \$8,000 or \$12,000. We all know that, and we all would love to find a way to insure against that.

Now, a couple of things that I would just like you to keep in mind, and then I would ask you to join with us. I would love to have a part C. I do not know that it necessarily has to be that, but I would like to have another piece to this legislation. There is only one problem in the benefits that I can see thus far, and I am sure there will be others, and that is definitional to keep the welfare cheat out. We have all heard the horror stories in other areas about the person getting services from the Government they are not entitled to. They are rich or they have got a summer estate that they have not sold, and they are receiving Medicaid benefits.

How do we define those who need long-term nursing care just because it would be more convenient and more comfortable for the kids to dump Mom or Dad there, and those who really need it? That's a very ticklish problem in writing the gatekeeper law.

If we could solve that, we then are dealing with only, as Hal describes, about 1 percent of the 30 million, about 500,000 people a year. I submit, then—I will not argue with you if you find a better way—that if we have only 1 in every 60 who are going to need this heavy catastrophic care, why do savings? Let us insure it, because then everybody has to put away a little less. But if, in fact, you want to do the savings plan, you hit the nail right on the head, Dave, and said the Ways and Means Committee and the Treasury are not going to go back and create another kind of IRA. And if it looks like an IRA and talks like an IRA—we fought that battle last year.

But there is in place 90 percent of what you want, and that is called a home, or a house. You can deduct your payments now virtually on two houses, almost to the extent that you could deduct an IRA contribution. For most people it is an interest payment. You take \$125,000 out tax free. You have got to take it out in a lump. If we could figure out a way for people to annuitize it, save the couple the problem by only making them annuitize half before they qualify for Medicaid, so you do not have the healthy spouse spending down, they would have a cash value. If they die before they annuitize it, the kids get what is left. It is in place. And 70 percent, think about this, 70 percent of the 30 million Americans who are on Medicare own their own home.

Now, about the other way, 70 percent of Medicare beneficiaries have incomes of under \$10,000 or \$12,000. So we have a funny disparity here. People who cannot afford the income but they have the assets. All I am saying, gentlemen, is I think in these numbers and in this constituent base, we would have no problem putting to-

gether the benefits. We all want them. There ought to be some minor costs so people do not overuse them. And then how do we pay for them?

Let us assume for a minute that in some future years when the deficit is reduced, we might even get some general revenues. But assume for a minute we have to make it budget neutral. I do not think this committee would have any quarrel. I am just saying I hope you will work with us because I know Mr. Gradison would like to expand this to include more. I am not sure—as you all know, we had a little trouble selling downtown even the little bit that we are doing in what is called now Gradison-Stark. That was a tough sell.

As I say, I think you get no quarrel from this committee—and I will let my colleagues speak for themselves—in expanding this. There is nothing I would rather have than something to get you all back as we mark this up to say, well, you want to join with us and cosponsor it, something that expands the benefits to add it. I think that we would get Senator Pepper, and I think each one of you at the table would find a way to support what we are trying to do because there is nothing new in it. It is all there, and we have researched it to death. We know who the people are, and we know what the costs are.

So believe me, it is not obstinate disregard of your interests. It is just a question of how we package all of this to sell it to the various groups we have to sell it to see it come into reality. Our theory has been let us take whatever we can get a step at a time and move ahead as long as we think of what we are doing. And what I hope is that you will not find the beginning parts of our catastrophic, our so-called catastrophic bill, will prejudice what you want to add to it later.

I think there is room for both of these to fit together in an expanded program, and I for one would like to work with you because you have testified before us before, I know of your interests in this, and I hope you will continue to share with us your ideas.

Mr. DAUB. Mr. Chairman, might I say just one point?

Chairman STARK. Sure.

Mr. DAUB. My fear in all this is, as we look at the estimated premium of \$4.92, going to \$6.40, going to whatever it will be in 1989 and 1990 and 1992 and 1994, as Bill Gradison said, we really need to get some independent cooking of these numbers.

I do not think our subcommittee still has the Secretary's numbers that we have been asking for, at least I do not think we have received them yet.

Chairman STARK. I think you are right.

Mr. DAUB. I think we have to be very cautious, because when we know that part B itself is essentially three-fourths funded out of general revenue—a point I think my colleague—

Chairman STARK. That is what I am afraid Senator Pepper's number comes from. I cannot quite figure out how \$19 billion is going to pay for all this unless it is only paying for a quarter of it. But we do not have all our numbers.

Mr. DAUB. And that is an important thing to look at. If a million people were added to the over-65 ranks now, and we are going to do that about each and every year for the next 20 years, we cannot

just handle the add-on to the voluntary part B premium. We have to think about the consequence of additional costs that pull up through the system. And then we might feel good about what we do on any catastrophic bill. But 2 to 5 to 10 years from now, when we get to where we already know the medical trust fund will have a problem, we are going to face an even more severe requirement for catastrophic coverage.

That is why in my suggestions for examination by the committee I look at a no premium kind of approach using an income-related test. I look at a "no tax increase" approach because I reapportion, if you look at the fine print of my proposal, the FICA increase that is coming in 1988 and in 1990 as a way of using what we have in excess at this point to provide that carefully targeted benefit in the future.

Chairman STARK. It is my understanding Medicare does not increase in 1988 and 1990 the way FICA does.

Mr. DAUB. No, but the FICA does.

Chairman STARK. Right.

Mr. DAUB. Put some of it over into our medical trust fund.

Chairman STARK. Well, or increase Medicare proportionately. It would not be very much, but there are some people who do not want any increase in taxes. And I can understand that.

Mr. DAUB. It is a way of looking, and my last point to what you said is that I really am concerned about a private benefit, a private sector balancer to whatever we may do.

If we can sweeten the kitty that we offer by adding politically, if you will, the Kerr-Mills idea of decades ago that opened up that group market to provide for a stream of retirement benefits, and if we can add to the definition of retirement health care benefit without invading the Treasury base line—which my bill does not do; it is revenue neutral—then we can have over a period of time, starting now, not waiting until 10 years from now, the potential for more elderly to independently finance the catastrophic costs of at least long-term nursing home care. At the same time we should not ruin—I call it cherrypicking or craning—the part B market right now, which may be medigap or supplemental, to a point where people say, "I do not need to take the voluntary premium as it increases because the Government will take care of me one way or the other." And there is reverse mortgage lending, Mr. Chairman, that is sucking the equity out of the elderly's homes now because of such things as keeping the roof fixed, paying higher property taxes and medical bills that are not covered otherwise.

So I think that as we get to 1995 we are not going to have all the equity in that house that we now have because of other costs that are creeping up on them.

Chairman STARK. Do not let the realtors hear you say that?

Mr. DAUB. Well, they ought to appreciate that we are ruining that equity market now by reverse mortgage lending.

Mr. CHANDLER. Mr. Chairman.

Chairman STARK. Mr. Chandler.

Mr. CHANDLER. I just wanted to compliment you on your comments, and I think that you have approached this in a thoughtful, responsible way. I have supported your bill, and I have supported the President's bill. Without naming names, I would like to suggest

that I think it was unfortunate that some of our colleagues have referred to the President's bill—and by reference yours, too—as a hoax because of its lack of coverage for long-term care, but without identifying their source of revenue to pay for what they consider to be the shortcomings of your legislation.

I almost wonder if, in the spirit of trying to communicate to many people out there who, according to what I found in my town meetings over the weekend, think Medicare already covers these things, let alone—

Chairman STARK. It has been like that for years.

Mr. CHANDLER. Yes, let alone what we are suggesting. Now, I think in the spirit of nothing better than good communications, why do we not invite those people who think this is a hoax here, and let them explain to us how to pay for correcting that inadequacy.

Chairman STARK. Come back tomorrow.

Mr. CRANE. If you would yield, Mr. Chairman. I do not know of anyone at this table that has described it as a hoax. I think—

Mr. CHANDLER. Oh, I was not referring to you, sir, no. They are in the other party.

Mr. CRANE. The only reason I think, though, that there is concern—and it is a concern that is addressed by the Slaughter bill—is for the long-term funding of the Medicare program itself, which everyone knows. I mean, the Ways and Means Committee had this big seminar in Deston, was it not? Was that not the seminar on health care funding?

In effect, most of the members attending said, well, the program is not going to go bankrupt in the 1980s, so we can all hit the links, because we have got a 10-year breather. And that is where I think we really should be taking a serious look at coming up with a private sector alternative.

My understanding though, Pete, was that both Secretary Bowen and Reagan did not rule out a health care savings approach.

Chairman STARK. No, they did not. The only concern I would have is that we are really dealing—if you take the history of the IRA's—with a small portion. Then we have got a worse problem.

We can also say we have solved the problem. The fact is that we would solve it for maybe at the most 25 percent of the people, and we would have the 75 percent whom we then load on, I suppose, to Medicaid and kick those costs.

It is interesting that we do save, not much. Our bill which is self-funding saves, perhaps, \$200 to \$300 million out of Medicaid, which previously has been picking up some of the gap that we cover that is now not covered by private insurance.

So it is all one package. You know, very few people in the country die on the streets without medical care. Somebody picks them up and shifts that cost to the county or to charity hospitals or to extra billing that you have got to pay for in your insurance because they are covering the uncompensated care in there. We do not have many people in this country who do not get attention. They may get it a little late or after the fact or grudgingly, and somebody is paying for that. It is no free lunch in this package.

We see it as how do we figure out benefits, the definitional problem, and then how do we pay for it?

Dave?

Mr. DREIER. Mr. Chairman, if I could just make a brief comment on something that you alluded to, it seems fascinating to me that right after we passed this landmark tax reform bill, everyone seems to be holding out that equity in the home as the panacea to almost every problem we have. And I think that the temptation to use the equity in that home to buy a refrigerator or an automobile certainly will outweigh any incentive that will be provided to create long-term health care.

So I think that is the reason that what French Slaughter is talking about is an important thing for us to move towards. And as I said, last year we supposedly turned the corner on it, and we are not encouraging—

Chairman STARK. I would just say this in that regard. I have to admit to my friend, Mr. Gephardt, that my Dad really was a realtor. [Laughter.]

But I have heard, you know, as between a savings account and a house, or, let us say, a condo in Ocean City and an extra savings account, is not a condo in Ocean City a whole lot more fun?

The point is I think that people enjoy owning a home. They love to decorate it and landscape it and furnish it and play in it, and a savings account, I can tell you as a former banker, is the most boring thing.

It is like quitting smoking. You know you should, but you do not ever get around to doing it.

A savings account and a diet are the two things that we all talk about a lot and do not have. But a house is fun. That is where you go for Thanksgiving.

So in spite of the fact that we may be inclined to borrow too much against it or get too far in debt to get one, it is so much a part of our culture, almost like savings accounts may be in Japan. And I say let us play to our strength. That is where people want to put their dough and save and take their tax deductions; it is all right with me, plus you will pick up the building trades and the realtors as cosponsors.

Mr. DREIER. But what incentive do we have, then, for them to plan for the health crisis?

Chairman STARK. The incentives are there, seriously, and they have been fostered by the savings and loans who want to mortgage loans by FHA, by veterans loans, by the tax deductibility of the taxes and of the interest. We have built incentives. How do we compensate for the poor renters because they really are left out of this package?

But I am suggesting that we have got incentives that have been built in to that whole housing program for years.

Mr. DAUB. Mr. Chairman, the question might be the incentive for health care, however, as distinguished from incentive for home residency. And I guess I would say that I, too, share your concern when you look at the IRA.

Now, I felt that we could do away with some of these things as we proportion the rates down. And so we look at the figures on IRAs, and the current IRA participation rates are lower than we had anticipated, to a degree. And to do this while under higher

rate structures, I would support the tax credit and the revenue cost of an IRA.

I knew the revenue costs would probably be the barrier to this approach, and so I struggled to find a different way to reach the objectives that Mr. Slaughter and Mr. Dreier have so ably brought before the Congress. That was to look at age 50 as that point when, with the house, I am going to lose a \$200,000 dependent exemption as my kids start to bump off and go elsewhere; that is a pretty nice deduction to start to lose. So I start thinking: I am more secure at age 50, my income stream may be more secure, my earnings higher; as I look at my itemized return, what if we minimize the revenue by an exclusion rather than a credit and not count up to—not the wealthy problem with the IRA and the credit, avoiding that—but say that if it is \$200, \$300, \$500, \$800, \$1,200, or \$1,500. You would want to put it on a premium that has a definition of long-term health care, and that premium that you use interest income to buy, that policy you buy, would be tax free and there would be a buildup inside of it that is tax free.

We do that now. We did not change that in tax reform. Then we minimize the revenue, we create savings up to age 50 from which interest income buys tax free——

Chairman STARK. But that is there now.

Mr. DAUB. It is not there.

Chairman STARK. Buy life insurance. The same thing.

Mr. DAUB. You mean cash out the one to buy the other?

Chairman STARK. After a certain age, life insurance was paid up. It does not make a difference. Most of it gets paid up early enough so that when they need nursing home care they do not need the protection any more.

Mr. DAUB. We are beating up but one set of savings that is already in place.

Chairman STARK. You know the biggest problem to use of the home equity or other savings for long-term care? Greedy kids. Our kids want the house.

Mr. DAUB. Mr. Chairman, as accurate as you are in your humor, the fact is if we look at this 10-year window ahead of us and take a couple of steps along with the part A and part B changes that we are intending to make, and we balance the package by adding something that says the individual gets a tax break if he buys that kind of policy and by providing coverage through companies and the workplace, then 10 years from now, this crisis we know is coming is not going to be as bad. We must be smart enough now to use the keys to open up some statutory changes to make that opportunity possible. That is our point, I think.

Chairman STARK. Seriously, your points are well taken, and I look forward to working with you.

Mr. Gregg.

Mr. GREGG. I would just like to make an observation. I think were I chairman of this committee I would sense that I am chairing a committee which is ready to move on an issue from the most conservative members on the committee to the most liberal members of the committee. And I am talking about long-term care. There is laid on the table here three or four truly excellent ideas. You have put an excellent funding mechanism idea top of that.

It just seems to me that if we move on this fringe part of the long-term care issue from a dollar standpoint without addressing the whole long-term issue at this time, we will be missing an opportunity.

Now, granted, I think the whole long-term issue is going to take a few more hearings and a little more process, and I guess the Chair may be under some constraints. He is not allowed that process by other forces that are at work here on the timetable.

But I hate to see us not at least take a run at this thing; maybe we cannot reach a funding mechanism, but to me to pass just the catastrophic plan, the Stark-Gradison plan, when it is really not catastrophic and when there is, I think, a mixture of elements which would be willing to move on catastrophic, is to pass up an opportunity. So I just throw that out.

Chairman STARK. If the gentlemen would yield, I agree wholeheartedly. My only reservation, is that if we are going to get the broad coverage that I think we all want to get so we deal with at least a large percentage of the beneficiaries or the people who need it, we have got costs in there that we cannot identify yet that will be high. And they could be general revenue costs.

As long as we are budget neutral, we could have a holiday. But the fact is that in some instances we may very well like the three-quarters of part B that it really comes out of general revenues. If that kicks up a lot, then we have OMB to deal with and CBO to deal with it, and then we are looking at something where you have taken the fun out of the legislating.

Mr. GREGG. My point is that we make a mistake if we do not look at that now.

Chairman STARK. Okay. I agree with you, and I am saying what we may have to do is take less and set the direction that we are going when we are willing to pay for it—whether it is through increased payroll taxes or increased general revenues. I think there is some cost, and I think Hal evidenced his concern that hidden in here may be some additional costs. If we thought we could do this on a budget neutral basis all the way, I would say it would be absolutely wrong not to. But that is the one thing that I am not as sure of.

Mr. GREGG. Well, if we take less, I think we are going to end up misleading more, and that is the problem I have.

Chairman STARK. I share that concern.

Mr. GRADISON. Mr. Chairman, I just think it is important to note that we are thinking along the same lines in terms of what we would like to do, and that the subcommittee is planning a hearing on that very point, specifically on the question of what we might be able to do in the long-term care field as part of this bill. The date is not yet set. The witness list is being worked on.

I think the gentleman from New Hampshire has made an excellent point, and I think that the witnesses, all of them, are attempting to move us in the right direction. The letter which Mr. Daub read to us is very similar to a series of letters that I have been receiving, which I am sure from their content are not some kind of an organized letter writing campaign, but are deep personal concerns of constituents who recognize how limited the additional benefits would be and what is currently on the table.

I believe that the concern out there, in my opinion, is not just on the elderly, but their children as well. I do not think it is just limited to the desire for inheritance alone. I think that there is also a genuine concern on the part of children about the psychological impact on their parents of losing their home, of the healthy spouse not even knowing where they can afford to live, and of seeing the accumulation of lifetime savings—which often may be a modest amount—wiped out not because of a lack of prudence and savings and hard work and all the virtues, but because of the bad luck of having expensive long-term illnesses in their later years.

Mr. DAUB. Well, you know, in about 10 years we are going to see an interesting demographic phenomenon in regard to the aging of the population. We are going to see a lot of 60-year-old sons and daughters alive thinking of their retirement in a few years and worrying continuously about their alive mother and father who are age 90. I mean, even now we face this problem, as we are going to have the 85 and older population go from 3 million to 6 million in the next 4 or 5 years. And it is going to be not a perception of reality but a real problem for us here in the Congress; we are going to see a serious erosion of confidence in the medical systems of our country.

So what I think all of us are concerned about, and I certainly am attempting to address this in my legislation, is to balance off this window of opportunity; to be revenue neutral but provide a few changes—minor as they may appear now—that over time can give our kids a chance to carry part of this burden for themselves and not think about their 90-year-old mom and dad being out of money and broke.

Chairman STARK. Thank you. I am going to ask, if I am not offending any of the witnesses or members of the committee, that we now change the topic. We have witnesses who were scheduled at 10:00.

I want to thank this panel. We do have work sessions among ourselves, and I hope that you all will make your interests known if you would like to work with us as we get into this, as I am sure we will later in the year.

[Whereupon, at 10:23 a.m., the hearing was adjourned subject to the call of the Chair.]

EXPANDING MEDICARE TO INCLUDE CATASTROPHIC COVERAGE

WEDNESDAY, MARCH 4, 1987

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:40 a.m., in room B-318, Rayburn House Office Building, Hon. Fortney H. (Pete) Stark (chairman of the subcommittee) presiding.

Chairman STARK. The subcommittee will commence with apologies to our witnesses and members who were far more prompt than the Chair.

We will hold our third hearing on capping out-of-pocket medical expenses for our Nation's elderly.

To help solve part of this problem, Congressman Gradison, myself, and 13 other members of the Ways and Means Committee have introduced H.R. 1280 and H.R. 1281, the Medicare Parts A and B Catastrophic Protection Acts of 1987.

This legislation deals primarily with limiting out-of-pocket expenses for lengthy hospital stays and high physician bills. Even though many have charged that this is not enough, it will still cost the Medicare program over \$4.53 billion in 1990 to provide these benefits. Benefits, that I might add, are long overdue, and very much needed by those with acute care illnesses and conditions.

A thousand mile journey begins with the first step. H.R. 1280 and H.R. 1281 take that first step in providing coverage for senior citizens.

Equally important, this legislation is financed in a progressive manner so that only the higher income older Americans pay for the expanded benefit. By taxing the subsidized portion of the actuarial value of Medicare parts A and B, 65 percent of low-income seniors will pay no additional tax.

We must ensure that any proposal to expand Medicare benefits is in a budget neutral fashion so that we do not increase our already unacceptable high deficits.

Our witnesses today will discuss the need for catastrophic coverage for older Americans, what catastrophic coverage should be included, what might be included, and a variety of ways to finance these coverages.

We can begin to end the grim spectacle of senior citizens being financially devastated by catastrophic acute illness. We can fill the

gaps in the Medicare coverage in the most efficient way, and I hope that we will all work together to achieve this goal.

And I am honored to have as our first witness today America's leading senior citizen, the House of Representatives first senior citizen, the distinguished gentleman from the State of Florida, the Honorable Claude Pepper.

Senator, welcome to the subcommittee. I am flattered, honored, and I look forward to your presentation.

STATEMENT OF HON. CLAUDE PEPPER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA, AND CHAIRMAN, SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE, HOUSE SELECT COMMITTEE ON AGING

Mr. PEPPER. Thank you very much, Mr. Chairman and members of the committee. I am grateful for the privilege of being here with you today, and I wish to commend this committee for its concern and its responsibility in respect to providing better health care for the people of our country.

Mr. Chairman, I first learned about a comprehensive health program for the people of our Nation in 1938, when a distinguished gentleman from the State of New York, Senator Robert Wagner, introduced a comprehensive health care bill. That was in 1938.

I have here before me, among the papers of President Harry S. Truman, a special message to the Congress recommending a comprehensive health program November 19, 1945. That is the second time I heard about a comprehensive program providing health care for the people of our country.

A year later, my Senate Select Committee on Wartime Health and Education, of which I was chairman, made a similar recommendation to the Congress. Nothing was done about the 1938 bill of Senator Wagner; nothing was done about the recommendation to the Congress by President Truman; and, of course, nothing was done about my committee's recommendation in 1946.

But, 20 years after the recommendation to the Congress of President Truman, then the Congress did step into the breach and enacted meaningful legislation in the Medicare and the Medicaid programs.

Now, what we are dealing with is the insufficiency, the inadequacy of the Medicaid program relating only to those in the lowest income groups, and the Medicare program which is the major and almost the only legislation favorably affecting health care for older Americans.

Now, then, what we are considering today, 22 years after we adopted Medicare in 1965, is a way of dealing with the deficiencies in the legislation we passed at that time. Now we have had 22 years of experience with Medicaid and with Medicare. We can reflect on the strengths and weaknesses of those programs.

Today, we have, by estimates that I think are sound, 20 million Americans who are chronic heart cases. We have 10 million Americans who are chronic lung disease patients. We have 5 million Americans who are subjected to cancer. We have 3 million Americans who are the victims of Alzheimer's disease, and we have 500,000 Americans who are the victims of Parkinson's disease.

Typical of these groups, there are two instances I would like to call to your attention. One of them was a letter I received when my Subcommittee on Health and Long-Term Care, a little bit ago, had a hearing. This was from an 83-year-old man from the State of Maine, and here is what he wrote:

Here I sit, the loneliest man that ever lived. I have admitted my wife of 55 years to a nursing home. She has Alzheimer's, and I am caught between a rock and a hard place. I can no longer provide the round-the-clock care she requires, and I will soon be unable to pay the cost of the care she now receives, which has exhausted our \$160,000 in life savings.

Another man, who personally appeared before our committee, said:

In 1983, my wife was stricken with cancer. In the year that followed, prior to her death, I spent over \$17,000 for her care, of which my four insurance policies paid only \$64. My own health has deteriorated. I suffered a stroke, have a liver disorder, and my leg was recently amputated. I require round-the-clock care, none of which is covered by Medicare and my insurance. I have almost exhausted my \$140,000 in savings.

Now, my dear colleagues, how many Americans have got \$140,000 and \$160,000 in liquid assets or in the bank? If those people out there in America understood the jeopardy in which they exist today, they would be shocked.

I had a notice one day from the doctor telling me my wife had cancer. Any other American may get it. There are 400,000 deaths from cancer in our country every year. So it is common among the elderly people, these people out there that think they are doing well.

This last witness I referred to, he said I had four insurance policies. "I had \$140,000 in the bank. I had a good job. My wife and I owned our home." And he said, "I thought I was all right." You see what happened to him.

We had four witnesses before our subcommittee the other day, and every one of them was what you call upper middle-class people. All of them owned their own home, all of them had many thousands of dollars in the bank, all of them were well employed. One of them was a lady who achieved executive status in a big department store. Every one of them had to sell their own home. And I remember one lady testified that she had to sell her home to continue to take care of her husband. She said, "I dared not tell him that we had to sell our home because it would have broken his heart."

Now, Mr. Chairman and members of the committee, the administration's proposal and the proposal submitted by your distinguished chairman are commendable. They make progress. But has not the time come when we should deal adequately with this problem? These measures that you are now considering do not deal adequately with home care; they do not deal adequately with nursing home care; they do not help the elderly with paying the \$10 billion they spend annually on prescription drugs. They do not provide eye care or hearing aids. These things cost about \$500 apiece. They do not provide dental care—a lot of elderly people cannot eat adequately because they do not have the teeth and they do not have the money to pay the dentist what it would cost to provide them with

the false teeth they need. They do not have foot care, which is a serious matter to a lot of elderly people.

My bill, H.R. 65, which I respectfully submit for your consideration, would take care of all these things. It would be comprehensive in its coverage of the elderly.

Now, I have another bill that I am preparing right now to take care of everybody, but I guess it is too much to expect that we should take care of everybody at this time. However, I do think, after all these years of experience with Medicare and Medicaid, we know enough about the deficiencies in the present system to deal adequately with it.

Now, my bill would mean nothing added to the deficit, nothing added to the debt. All the money that is required is provided for in the bill. I have the word of the Congressional Budget Office that it is budget-neutral, and they are making a specific detailed study now of the bill so they can report to you and all the rest of us in the Congress just exactly what the effect of the bill would be.

We provide that what elderly people pay for health care shall not exceed 10 percent of their income, and not exceed \$800 a year. Our study proves that, on the average, the elderly are spending now \$1,500 a year for health care, including medigap insurance, which is grossly inadequate to meet their needs and to pay medical bills that they have, including drug bills. So it would be a big saving. That is, I said nobody would have to pay more than 10 percent of his or her income for health expenses.

Now, if that is not enough, we have provided an alternative source of revenue in our bill, simply raising the base that is now at \$43,800 as high as is necessary to cover that kind of comprehensive care.

As far as I am personally concerned, if we all pay that same percentage of tax on our total income, no one will experience any financial hardship. Yet, everyone will be protected against possible bankruptcy, which can result when a catastrophic illness strikes.

But I am simply emphasizing we have tried to provide the revenue, and we will have before you, by the time you come to the final consideration of these proposals, we will have before you this detailed study of the Congressional Budget Office upon which you can rely, documenting the soundness of the bill.

So what I am saying, Mr. Chairman, and I want all of you, everybody who proposes to better the system that we now have, to consider this, is how much longer are we going to have to wait? Well, what else do we need to do? What do we need to learn that we do not already know? We know how to draft legislation. The data tells us all over the country the severity of the needs. All these people out there are depending on us, and I think now American opinion is even a little ahead of us.

For example, I was up in Philadelphia holding a hearing a couple of years ago, and all over the room there were signs, National Health Insurance, National Health Insurance.

I was out in Los Angeles at the convention center, and all over the room were these signs. I said to Senator Kennedy, when I saw him, I said, "You know, Ted, I do not know but what the people are getting ahead of us." So now I am afraid of this, Mr. Chairman and distinguished members, I am afraid we will not take full advantage

of this public opinion. Think there is more favorable sentiment in Congress today for positive legislation on the subject of health care than I have seen since I came here 50 years ago.

So I am simply saying if we pass up this opportunity, we are not going to turn around and legislate again on this subject at the end of the session or the next session, I am afraid we will wait another 20 years.

So I beg of you, Mr. Chairman. I know of your keen interest, your wisdom and knowledge, I beg of you let us try to do a full job in a sound way this time.

[The prepared statement follows:]

NEWS

CLAUDE PEPPER, Chairman
Subcommittee on Health and Long-Term Care
House Annex 2, Room 377
Washington, D.C. 20515
202/226-3381



Select Committee on Aging

U.S. House of Representatives

FOR IMMEDIATE RELEASE
WEDNESDAY, MARCH 4, 1987

CONTACT: KATHY GARDNER
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STATEMENT OF
CONGRESSMAN CLAUDE PEPPER, CHAIRMAN,
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE
OF THE
U.S. HOUSE SELECT COMMITTEE ON AGING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
WAYS AND MEANS COMMITTEE
ON

"CATASTROPHIC HEALTH INSURANCE FOR OLDER AMERICANS"

MR. CHAIRMAN. MEMBERS OF THE SUBCOMMITTEE. LADIES AND GENTLEMEN. I WANT TO THANK MY DISTINGUISHED COLLEAGUE AND CHAIRMAN OF THIS SUBCOMMITTEE, THE HONORABLE PETE STARK, OF CALIFORNIA, FOR THE PRIVILEGE OF LETTING ME TESTIFY ON A MATTER OF IMMENSE IMPORTANCE TO OUR NATION'S 31 MILLION ELDERLY AND DISABLED, THAT IS THE NEED IN THIS COUNTRY FOR COMPREHENSIVE CATASTROPHIC HEALTH INSURANCE.

MR. CHAIRMAN. OVER THE COURSE OF THE LAST FOUR YEARS, MY SUBCOMMITTEE HAS HELD DOZENS OF HEARINGS ON THE ISSUE OF CATASTROPHIC HEALTH INSURANCE, BOTH IN WASHINGTON, D.C. AND AROUND THE UNITED STATES. LITERALLY HUNDREDS OF ELDERLY MEN AND WOMEN HAVE APPEARED BEFORE MY SUBCOMMITTEE TO DETAIL THEIR PERSONAL EXPERIENCES IN COPING FINANCIALLY WITH A HEALTH CARE TRAGEDY. ELDERLY AMERICANS ARE AFRAID. EVERY DAY THEY FACE THE DOUBLE-EDGED SWORD OF EVER-ESCALATING HEALTH CARE COSTS AND CONSTANTLY DECREASING MEDICARE COVERAGE. EVERY DAY, THEY FEAR GOING BROKE, LOSING THEIR HOME TO A LONG-TERM ILLNESS, GOING INTO A NURSING HOME, OR BECOMING DEPENDENT ON A STRANGER OR A LOVED ONE. MOTIVATED BY SUCH FEAR, MY SUBCOMMITTEE HAS FOUND THAT SENIOR CITIZENS BUY HOPE IN THE FORM OF ONE OR MORE INSURANCE POLICIES, NOT REALIZING THAT THERE IS NO PUBLIC OR PRIVATE INSURANCE POLICY, OR COMBINATION OF SUCH POLICIES, THAT WILL PROTECT THEM WHEN A CATASTROPHIC ILLNESS STRIKES AND PROVIDE THEM WITH THE COMPREHENSIVE COVERAGE THEY SO DESPERATELY WANT.

WHILE MEDICARE AND PRIVATE INSURANCE DO A PRETTY GOOD JOB OF PAYING COSTS ASSOCIATED WITH HOSPITAL STAYS -- VIRTUALLY NO COVERAGE IS AVAILABLE FOR THE 20 MILLION AMERICANS WHO SUFFER FROM CHRONIC HEART CONDITIONS, OR THE 10 MILLION AMERICANS WHO SUFFER FROM CHRONIC LUNG DISEASE, THE 3 MILLION AMERICANS WHO HAVE ALZHEIMER'S DISEASE, THE 5 MILLION AMERICANS AFFLICTED WITH CANCER, OR THE 500,000 AMERICANS WHO HAVE PARKINSON'S DISEASE. IT IS A FACT THAT ONCE A PERSON BECOMES SO DESPERATELY ILL THAT THERE IS NO HOPE OF MAKING HIM OR HER SELF-SUFFICIENT, MEDICARE AND MOST PRIVATE INSURANCE COME TO AN END, AND THE PATIENT AND HIS OR HER FAMILY ARE LEFT TO FEND FOR THEMSELVES. THE SUBCOMMITTEE HAS FOUND THAT LIFE SAVINGS CAN QUICKLY BE DEPLETED FROM COSTS ASSOCIATED WITH A CATASTROPHIC ILLNESS -- WITH LONG-TERM CARE IN THE HOME OR IN A NURSING HOME RANGING FROM \$25,000 TO OVER A MILLION DOLLARS A YEAR.

THE OPTION FOR CHRONICALLY ILL AMERICANS WHOSE RESOURCES ARE EXHAUSTED, OR NON-EXISTENT, CAN BE EQUALLY FRIGHTENING. ONE IS ADVISED TO WAIT UNTIL ALL LIQUID RESOURCES, INCLUDING ONE'S HOUSE, ARE DEPLETED TO THE LEVEL OF \$3,000 FOR A COUPLE AND \$2,500 FOR AN INDIVIDUAL -- AND THEN GAIN MEDICAID ELIGIBILITY.

IN 1987, OVER 700,000 OLDER AMERICANS WILL BE FORCED INTO POVERTY AND ONTO THE WELFARE ROLLS DUE TO THE CATASTROPHIC COSTS OF THE HEALTH CARE THEY NEED.

WHILE I AM PLEASED THAT THE PRESIDENT NOW AGREES THAT WE MUST FIGHT OUR BATTLE AGAINST THE BANKRUPTING COSTS OF A CATASTROPHIC

ILLNESS, I AM SHOCKED THAT HE WOULD KNOWINGLY OR UNKNOWINGLY LEAD THE AMERICAN PEOPLE TO BELIEVE THAT THE PLAN HE ENDORSED WOULD "FREE THE ELDERLY FROM THE FEAR OF CATASTROPHIC ILLNESS" AND PROVIDE "THAT LAST FULL MEASURE OF SECURITY." THAT CLAIM IS SIMPLY NOT TRUE.

THE PRESIDENT'S PLAN SIMPLY COVERS LONG HOSPITAL STAYS -- WHICH LESS THAN 1 PERCENT OF THE ENTIRE MEDICARE POPULATION CURRENTLY REQUIRES. IN EXCHANGE FOR A \$4.92 MONTHLY PREMIUM, MEDICARE WOULD COVER AN UNLIMITED NUMBER OF DAYS IN A HOSPITAL, WITH EACH MEDICARE BENEFICIARY PAYING NO MORE THAN \$2,000 EACH YEAR IN COINSURANCE AND DEDUCTIBLES. SIMPLY PUT, HIS PLAN WOULD HELP ONLY 3 PERCENT OF THE TOTAL MEDICARE POPULATION. A POLICY EXPERT FROM HARVARD TOLD MY SUBCOMMITTEE LAST WEEK THAT THE WHITE HOUSE PLAN WOULD HELP ONLY ABOUT ONE-TENTH OF ONE PERCENT OF ALL MEDICARE PATIENTS AT THE MASSACHUSETTS GENERAL HOSPITAL. THE PRESIDENT'S PLAN WOULD NOT COVER THE HEALTH CARE COSTS FOR VICTIMS OF ALZHEIMER'S, PARKINSON'S, HUNTINGTON'S, CHRONIC HEART OR ARTHRITIC PROBLEMS, CANCER AND THE LIKE. HIS PLAN WOULD NOT COVER LONG-TERM CARE IN THE HOME OR IN A NURSING HOME -- WHICH IS THE REAL CATASTROPHE FOR OLDER AMERICANS. IT DOES NOT COVER PRESCRIPTION DRUGS WHICH COST OVER \$10 BILLION ANNUALLY. IT WILL NOT COVER HEARING AIDS WHICH AVERAGE AROUND \$500 EACH. HIS PLAN WOULD NOT COVER EYE CARE, FOOT CARE, DENTAL CARE, PHYSICAL EXAMS.

I HAVE RECEIVED THOUSANDS OF LETTERS FROM SENIOR CITIZENS ACROSS AMERICA SINCE THE PRESIDENT'S ANNOUNCEMENT ON CATASTROPHIC HEALTH CARE. NOT ONE LETTER HAS COME FROM THE VICTIM OF A LONG AND UNCOMPENSATED HOSPITAL STAY. SADLY, MOST WRITERS BELIEVE THAT THE PRESIDENT'S PROPOSAL WILL PROVIDE THE ASSISTANCE THEY SO DESPERATELY NEED. BUT THE PRESIDENT'S PLAN WON'T HELP THE 83-OLD-GENTLEMAN FROM MAINE WHO WROTE ME STATING:

...HERE I SIT THE LONELIEST MAN THAT EVER LIVED. I HAVE ADMITTED MY WIFE, OF 55 YEARS, TO A NURSING HOME. SHE HAS ALZHEIMER'S AND I AM CAUGHT BETWEEN A ROCK AND A HARD PLACE. I CAN NO LONGER PROVIDE THE ROUND THE CLOCK SHE REQUIRES AND I WILL SOON BE UNABLE TO PAY THE COSTS OF THE CARE SHE NOW RECEIVES WHICH HAVE EXHAUSTED OUR \$160,000 IN LIFE SAVINGS.

THE PRESIDENT'S PLAN WON'T HELP AN ELDERLY GENTLEMAN FROM MARYLAND WHO TESTIFIED BEFORE OUR SUBCOMMITTEE SEVERAL WEEKS AGO. HE SAID,

...IN 1983, MY WIFE WAS STRICKEN WITH CANCER. IN THE YEAR THAT FOLLOWED PRIOR TO HER DEATH, I SPENT OVER \$17,000 FOR HER CARE, OF WHICH MY FOUR INSURANCE POLICIES PAID ONLY \$64. MY OWN HEALTH HAS DETERIORATED -- I SUFFERED A STROKE, HAVE A LIVER DISORDER AND MY LEG WAS RECENTLY AMPUTATED. I REQUIRE ROUND-THE CLOCK CARE ALL OF WHICH IS UNCOVERED BY MEDICARE AND MY INSURANCE. I HAVE ALMOST EXHAUSTED MY \$140,000 IN SAVINGS.

NOW, HOW MANY OLDER AMERICANS HAVE \$140,000 OR \$160,000 LYING AROUND? NOT MANY. THESE TWO GENTLEMEN ARE TYPICAL VICTIMS OF CATASTROPHIC ILLNESS IN AMERICA. THESE GENTLEMEN WEREN'T LIVING ON THE FRINGES OF POVERTY. THEY HAD SAVED ALL THEIR LIVES. THEY WERE PROPERLY INSURED. THEY THOUGHT THEY WOULD BE SAFE WHEN A HEALTH PROBLEM AROSE, AND THEY, LIKE THOUSANDS OF OTHERS, WEREN'T. UNFORTUNATELY, THEY WON'T BE HELPED BY THE PRESIDENT'S PLAN EITHER.

ANY SERIOUS CATASTROPHIC HEALTH CARE PROPOSAL SHOULD COVER NOT ONLY LONG STAYS IN A HOSPITAL BUT LONG STAYS IN THE HOME OR IN A NURSING HOME AS WELL. IT SHOULD COVER ILLNESSES LIKE CANCER, ALZHEIMER'S, PARKINSON'S, HUNTINGTON'S, HEART DISEASE, AND THE LIKE, THAT DO NOT REQUIRE HOSPITALIZATION AND WHICH ARE LARGELY UNPROTECTED BY INSURANCE EITHER PRIVATE OR PUBLIC.

I KNOW, MR CHAIRMAN, THAT YOU HAVE INTRODUCED LEGISLATION THAT WOULD IMPROVE UPON THE WHITE HOUSE PROPOSAL. YOU ARE TO BE

COMMENDED FOR RECOGNIZING THE LIMITED NATURE OF THAT PLAN. SPEAKING FOR OLDER AMERICANS, I AM COMPELLED TO POINT OUT TWO SERIOUS WEAKNESSES IN YOUR PROPOSAL. FIRST, IT FAILS TO ADDRESS LONG-TERM CARE FOR THE CHRONICALLY ILL AT HOME OR IN A NURSING HOME. SECOND, TAKING OF MEDICARE BENEFITS, IN ANY FASHION, CAN ONLY BE REGARDED AS A SHIFT AWAY FROM A SOCIAL INSURANCE PROGRAM AND A SHIFT TOWARD TURNING MEDICARE INTO A MEANS-TESTED WELFARE PROGRAM. I AM HERE TODAY BECAUSE I BELIEVE THAT FOR THE FIRST TIME IN MY CONGRESSIONAL CAREER, WHICH SPANS 50 YEARS, THE PRESIDENT, THE CONGRESS AND THE PEOPLE ARE ALL STANDING ON THE SAME SQUARE. WE ARE FACED WITH THE RARE OPPORTUNITY FOR REAL, LASTING, MEANINGFUL CHANGE WITH RESPECT TO THE FUTURE OF HEALTH CARE. WE CANNOT, IN GOOD CONSCIENCE, WASTE THIS OPPORTUNITY WITH LIMITED REFORM.

I URGE YOUR CONSIDERATION OF H.R. 65, LEGISLATION I HAVE INTRODUCED WHICH WOULD IN FACT PROVIDE OLDER AMERICANS WITH CATASTROPHIC AND COMPREHENSIVE COVERAGE THEY ARE HOPING FOR. HR. 65 PROVIDES COVERAGE FOR LONG OR SHORT STAYS IN A HOSPITAL, IN THE HOME, OR IN A NURSING HOME. IT WOULD COVER MANY ITEMS CURRENTLY UNCOVERED BY MEDICARE OR PRIVATE INSURANCE, INCLUDING DENTAL CARE, EYE CARE, HEARING CARE, PRESCRIPTION DRUGS, FOOT CARE, AND PHYSICAL EXAMS.

H.R. 65 WOULD NOT ADD ONE DOLLAR TO THE FEDERAL DEFICIT. IT IS COMPLETELY SELF-FINANCING. IT WOULD INVOLVE A MORE SENSIBLE AND EFFICIENT MANAGEMENT OF OUR HEALTH CARE DOLLAR AND HEALTH CARE SERVICES. MY BILL BUILDS ON THE SUCCESS OF THE KAISER PERMANENTE GROUP IN OREGON WHICH IS PROVIDING COMPREHENSIVE CARE WITHIN THE COSTS OUTLINED IN H.R. 65. IT BUILDS UPON THE SUCCESS OF THE ON LOK PROGRAM IN SAN FRANCISCO WHICH HAS BEEN ABLE TO PROVIDE MORE COMPREHENSIVE CARE WHILE ACTUALLY REDUCING THE COST TO THE FEDERAL GOVERNMENT AND THE STATES.

THIS COMPREHENSIVE PACKAGE OF BENEFITS WOULD BE FINANCED, IN PART, BY THE AMOUNT MEDICARE PAYS NOW FOR SERVICES UNDER PARTS A AND B OF THE PROGRAM, AND IN PART, BY THE AMOUNT MEDICARE BENEFICIARIES CURRENTLY PAY FOR PARTICIPATION IN PART B OF THE MEDICARE PROGRAM (17.90 A MONTH) AND THE AMOUNT THEY SPEND PER MONTH ON MEDIGAP INSURANCE (ABOUT \$50 A MONTH). IN NO CASE WOULD ANY SENIOR CITIZEN PAY MORE THAN 10% OF THEIR INCOME ON HEALTH CARE PREMIUMS IN A GIVEN YEAR. IN ADDITION, STATES WOULD PURCHASE COVERAGE UNDER H.R. 65 AT A RATE EQUAL TO 90 PERCENT OF THEIR PROJECTED AVERAGE MEDICAID PAYMENTS FOR THESE INDIVIDUALS IN THE FOLLOWING YEAR. WHILE H.R. 65 WOULD PERMIT AMERICANS TO GO TO ANY DOCTOR THEY DESIRED, QUALITY OF CARE AND ACCESSIBILITY OF SERVICES WOULD BE REQUIRED UNDER MY BILL.

IN SHORT, H.R. 65 IS A COMPREHENSIVE AND CATASTROPHIC HEALTH CARE PLAN FOR OLDER AMERICANS. IT IS A MEANINGFUL, AFFORDABLE AND LASTING RESPONSE TO THE HEALTH CARE CRISIS WE NOW FACE. I URGE YOU, MR. CHAIRMAN, TO GIVE FULL CONSIDERATION TO THIS BILL AND ITS OBJECTIVE -- COMPREHENSIVE HEALTH CARE FOR OLDER AMERICANS. IT WOULD BE A TRAGEDY TO ACCEPT LESS, AT A TIME WHEN THE NATION IS READY TO DO SO MUCH MORE.

Chairman STARK. Senator, I could not agree with you more. And I would be honored to join with you in adding H.R. 65 to our bill, either incorporating it, using it as the lead, or creating a new part C.

I have one fear. I suspect on this committee, and certainly the Chair shares your concern for the benefit goals 100 percent. There is no question in my mind that those are the benefits that the public wants, and indeed that they should be provided. And I think we know what those cost in today's terms.

I do have some real question about how we are going to pay for it.

Now, I am with you personally, without subjecting my distinguished colleagues on the subcommittee that might very well prefer to be in the position of saying let us trade an old nuclear battleship for part of this. But we are not going to have that chance. At least the Rules Committee maybe could do that, but this committee cannot.

In our discussions anticipating your testimony, the problem that we are going to have is how could we agree to pay for it. Let me just review for you where we have gotten tentatively in our discussions with CBO.

Your new part C premium, of approximately \$50 a month, would raise about \$18 billion. If you eliminate the wage cap on only the health part of the FICA tax, you only get about another \$7 billion for a total of \$25 billion. The benefits that you would like to provide and I would like to provide would probably add almost \$68 billion to the cost. So we come up short, as we see it, with around \$40 billion.

Now, we could raise that \$40 billion if we took the wage cap off the entire FICA tax, but that is a big chunk. Now, that means that everybody making over \$44,000 would be paying a total between employer and employee of around 15 percent on the money between \$44,000 and \$100,000. So a guy making \$100,000 today would pay an extra \$840 from the time they were working, I mean their entire life, not just the seniors. Actually, I am not sure I have any quarrel with that.

We would have to do one other thing though. If you raise the wage base on Social Security so you pay, no matter how much you earn, you have to limit the benefits. Now, under Social Security, we have always said the benefit follow your income all the way up, and the only reason we cap benefits is because we cap the amount of wages you pay on it. You would have to get into a new philosophic fight here, and I am not sure you would win. But I am just suggesting here is the thing. If you say we are going to pay FICA tax on earned income to infinity, but cap the retirement benefit and use that extra money for almost unlimited medical benefits, that sounds pretty intriguing to me. But I am not sure that it gets beyond the bounds of this committee, this subcommittee.

But that is what we are facing in terms of the magnitude. Now, I am sure that you and I could be very proud of a cooperative venture if we did just a little of that this year. I have always been perfectly willing to be the tail of the camel, knowing that my friend, the head, is under the tent. I will get there eventually. And I just think that if we maybe get there a little bit at a time, I think the

only discussion that would come between you and others who have testified, both from our subcommittee, from both sides of the aisle. Some would like savings plans. There is a host of ways that people said we could raise this money. I will suggest one that will be new.

Yesterday, our distinguished Speaker suggested a transfer tax on securities. And my phone rang off the hook from securities dealers in business, but it was certainly a new approach. We might very well say let us take earned income, not earned transfer, but just earned income, and add it to the FICA base. That is not wages, that is a lot less than the Speaker was suggesting, and it would not necessarily go to deficit reduction. But there are a lot of ways to raise this money. With this committee's great record of bipartisan cooperation, I think that you will hear from some of my colleagues this morning that they would like to proceed right down the road that you mapped out for this morning.

And I hope that if we can make a start in that direction, and we share the same goals, that we can get your support and your participation in designing it. I am not sure we can get the whole ball of wax this year. But we are going to try, and we would certainly like your help.

I really thank you for coming forward this morning because you set some tough goals for us. I think we are going to try our best to stay within this concept of budget neutrality. I might suggest going a little farther into debt to do it, but I do not think I would get the votes. So that is what we can suggest this morning.

Mr. Gradison.

Mr. PEPPER. Mr. Chairman, may I just thank you for the very kind words that you have said and the encouraging things that you said.

We estimate that the elderly people are now spending on the average \$1,500 a year paying premiums on medigap insurance and paying medical bills and paying drug bills.

Now, under our bill, they would only pay about \$600 or \$800 a year, so it would be half of what they are spending on the average now. Nobody would be hurt particularly by paying up to 10 percent of his or her income. Then the doctors' bills and the drug bills and the hospital bills and the nursing home bills would all be paid.

Chairman STARK. But, Senator, that only raises \$18 billion, as I understand it.

Mr. PEPPER. We estimate that \$25 billion would come in from that source.

Chairman STARK. No. I think \$50 a month is \$600 a year times 30 million Americans is \$18 billion in round figures. It may be \$31 billion, but am I right on the premium part?

Mr. PEPPER. Well, we thought it might run as high as \$70 a month.

Chairman STARK. Oh, I see. Then you have got it. Let us go for a hundred. [Laughter].

And add dental care.

Mr. PEPPER. That is half of what they are spending now on the average, and the other one is we do not contemplate anybody but the employees paying. We are not adding on here, because we do not want to interfere with the bands that are pinching and the like. We are just talking about the employees raising it, going

above \$43,000 in their income. And we estimate that would raise between \$15 and \$20 billion from that source.

But, anyway, we will have a study from CBO that will advise us all in this method.

Thank you, Mr. Chairman.

Chairman STARK. Thank you.

Mr. Gradison.

Mr. GRADISON. Mr. Chairman, I certainly want to join with you in congratulating our colleague, the distinguished chairman of the Rules Committee, for moving this debate forward and encouraging us to broaden our horizons.

I also want to say I think it is extremely important as we work on this issue that we do not blow the chance to do something by trying to do too much.

One of the virtues of the two bills before us so far, the bill which our chairman and I worked on with others on the subcommittee and the administration's bill, from a financing point of view, is that they do not call on present workers or their employers to put any more money into the fund. Both plans, although in different ways, finance the acute catastrophic benefit from charges on the elderly themselves, period.

Now, to the extent that we broaden our view as to possible benefits and start getting into what could be an extremely broad-based tax on all workers and their employers, we get into a lot of other constituencies here, and we run the risk of losing the opportunity of making a small step in our understandable desire to take a giant step forward in this area.

The only other point I want to make is that as one who believes we should seek ways to move in the direction of protection for long-term care expenses, I would like to see us try to figure a way to do it through a program which has a catastrophic benefit. I think that one of the charms of the bills before us right now is that they do leave room for private insurance and savings to fill that gap up to \$1,500 or \$2,000. And with regard to whatever we might do in long-term care, I think it important that we avoid anything that might have the effect of first dollar insurance. That would be highly inflationary, discourage private savings, and move in a direction contrary to recent trends in health care financing, both in the public and private sectors.

I mean these most sincerely as constructive comments because I am impressed by the depth of your concern and very grateful for the leadership that you have shown over the years on this and so many other issues of vital concern to all of our elderly constituents.

And I thank you, Mr. Chairman.

Mr. PEPPER. May I just say to my able friend two things. One is, as I said to the distinguished chairman, we do not contemplate the employer paying into this fund out of the increase, just the employees.

The second is, yes, I want to emphasize that the primary responsibility for the implementation of our program would be through private providers, insurance companies, HMOs, medical units, hospitals, anything that is responsible, that takes the responsibility of doing what the law requires. So we are just like the Chrysler Motor Co. plan now. They contemplate the Government designating them

to carry out maybe the Medicare program. We want private providers involved to the greatest extent possible.

Now, if nobody is available, it would have to be done through Medicare. So I just wanted to mention those two things. Thank you.

Chairman STARK. Thank you very much.

Mr. Coyne.

Mr. COYNE. I would just like to thank Congressman Pepper for coming here today and giving us the benefits of your vast experience and knowledge on this subject that I know you have had a long interest in. Thank you.

Mr. PEPPER. Thank you very much.

Chairman STARK. Mr. Chandler.

Mr. CHANDLER. Senator, if I could ask a question about the effect on the States of your legislation. It is not clear to me in your testimony when you say, on page 3, States would purchase coverage under H.R. 65 at a rate equal to 90 percent of their projected average Medicaid payments for these individuals in the following year.

Mr. PEPPER. We wanted to give the States an opportunity to come into our plan. Whereas, today, the Government, through HCFA, and the Medicare plan, pays 95 percent of the estimated cost of medical care per patient under the Medicare plan to an HMO for example. We have said if the State would pay 90 percent of what they estimated it cost them to provide medical care for that patient under Medicare, we can bring them under our plan, and we think they can save money and we can provide even more comprehensive care than they are giving them now.

Mr. CHANDLER. Then who ends up being the one who pays more than they are now, the current employees?

Mr. PEPPER. Who is that?

Mr. CHANDLER. Who in society ends up paying more than they are paying now, besides the beneficiaries?

Mr. PEPPER. The beneficiaries, the elderly people who are the beneficiaries of this comprehensive health plan would pay a little more, but only about half as much as they are now spending.

Mr. CHANDLER. But the big hit would be on people who are working today. Is that correct?

Mr. PEPPER. That is right. The elderly people who are covered when they register into this program. They would have to pay an amount not to exceed \$70 a month, and not to exceed about \$800 a year, which is about half of what they are now spending for Medigap insurance and for medical care. So they would pay that in, and that would be the total medical bill. They would not have any more expense.

Mr. CHANDLER. Mr. Chairman, I would like to express one concern that I think is often overlooked. There is obviously a great need for this type of coverage for the elderly. That has been well documented. I think there is also a very real concern about the lack of coverage for many currently working Americans as well, the same people who will end up, as I understand H.R. 65, paying additional taxes to fund benefits for the elderly.

I am very concerned that we not make it even more financially difficult for people who lack coverage from their employers. If you look at the demographics of business today, those businesses that

are being started in this country are small and not organized by organized labor. They do not provide pension and health benefits coverage for their employees. It is to these people we are saying: in addition to what you already do not have in the way of benefits provided for you by yourself and your employer, now we are going to say you have to pay more taxes so that we can fund this for the elderly.

That may be what we want to do. But I think we have to look at that fact and remember nothing is free in this. To be honest with you, sir, I was disappointed when, over the weekend, I heard you quoted as saying the proposals by our chairman and the President are a hoax because there do not provide for long-term care. And I would respectfully suggest to you that perhaps they are realistic and not a hoax.

Mr. PEPPER. If my friend will permit me, this is nothing in the world but the same principle as Social Security we require, and just the same principle as Medicare. We require these payments as they are spent, in what we call a pay-as-you-go system.

What we are offering is a mandatory insurance program which would eliminate the need for these people who are going to get this care from having to buy private insurance to supplement what they are now getting, or from having to pay an additional medical fee and the like.

So this is the best deal. Look at these two men I told you about here that had \$140,000 and \$160,000 in the bank. If they had paid in like I am talking about, which would not have hurt them, they would have saved their money. And most of the American people cannot afford a long illness today which they may be subjected to. So this is nothing in the world but mandatory insurance.

I want to emphasize that I wish the insurance companies could write this kind of a policy, but maybe in time they will be able to. I want to use them, I want to use the insurance companies as much as possible, use everybody, every private provider as possible.

But we are offering a comprehensive medical policy to the American senior citizen and we are offering it at about half of what you ordinarily pay. But we remove from your heart the fear of catastrophic illness.

Chairman STARK. Would the gentleman yield?

Mr. CHANDLER. Absolutely.

Chairman STARK. I would also encourage you, Senator, as you get the numbers, because it follows as night follows day, to look at the additional costs, as long as we are planning under the bill that you have proposed, to add payroll taxes, to look at the cost of say picking up what is called the catastrophic coverage for younger people with some kind of a deductible of \$10,000 or \$15,000 that might be covered in most plans. Why do we not, while we are at it, take the cost of cancer, childhood diseases, rare diseases, or AIDS which now costs \$140,000 a case, and once a family reached \$15,000 or \$20,000 out-of-pocket, or whatever the amount is, that they would be covered under that just as they are covered under disability for social security now. Because it is the next logical step if we follow along H.R. 65. And we might as well begin to think in terms of what those costs may be in the future.

Mr. Moody may inquire.

[Mr. Moody submitted the following:]

REMARKS OF HON. JIM MOODY, ON CATASTROPHIC HEALTH COVERAGE FOR THE ELDERLY

Thank you, Mr. Chairman. I want to commend you for your determination to move legislation to alleviate the very real financial fears of millions of elderly Americans facing the possibility of an acute catastrophic illness. I am pleased to be an original cosponsor of the Stark-Gradison catastrophic health care bill.

Health care costs are a pressing concern for the nation's 30 million elderly. Medicare does a reasonably good job of meeting their routine or acute health care needs. Even so, the elderly will pay tens of billions of dollars this year in out-of-pocket medical expenses, even after their Medicare benefits.

Senior citizens facing catastrophic illness have very right to be worried. As Chairman Stark has pointed out, last year, over 20 percent of our senior citizens were forced to spend 15 percent of their income on medical care, while 7 percent were forced to spend one-quarter of their income on such care. For the 50% of senior citizens with incomes of \$10,000 or less, major illness cannot help but to be a financial disaster.

It is long past time for us to take direct action to address the need for relief from catastrophic health care costs. HHS Secretary Bowen has done a remarkable job in impressing upon the White House the urgency for action on catastrophic health care, and the Bowen plan is certainly a step in the right direction.

But the Stark-Gradison plan is more comprehensive, and does a better job of limiting out-of-pocket costs for catastrophic care for the elderly.

It also does a better job of financing the cost of catastrophic coverage equitably and ensuring budget neutrality. The Bowen plan would be financed through level premiums, estimated by CBO at about \$6 per month in 1988, and as much as \$12.20 per month in 1992. Level premium financing is regressive, putting the largest burden on lower income seniors who can least afford to pay. Moreover, to the extent that Medicaid would presumably pay the premium for qualifying low-income seniors, there are legitimate questions about the plan's real budget neutrality.

In contrast, the Stark-Gradison plan uses tax-based financing to pay for the plan. By assigning an actuarial value to that portion of Part A and Part B financing not paid by the beneficiary, and requiring that the value be included in AGI, the Stark-Gradison plan ensures budget neutrality, and bases its financing on the principle of progressivity embodied in the tax code. Even so, 65 percent of Medicare beneficiaries will have no added tax liability, since they are not required to file an income tax return. The plan simply requires those who should pay for coverage to do so.

I suspect that we'll hear from some witnesses today who will oppose the tax-based financing mechanism in the Stark-Gradison plan, so I look forward to a lively debate. Whatever the ultimate shape of the catastrophic plan to be reported out of this Subcommittee, I intend to do all I can to see that it is enacted.

Mr. MOODY. Senator, thank you so much for coming today. We appreciate the important contribution your proposal makes to us, and I think all of us are very sympathetic with what you want to do.

I have just one caveat I would like to attach to my support, namely, I think the proposal should be basically generationally neutral so that one generation should pay for itself, as we go along. And if there is a financing device that you can find which does that, then I am very interested in helping. But that would be my concern.

I do not want to see the FICA taxes increased any further. They are already at 7.15. They will soon jump to 7.51. And to have those go higher would bother me a lot because there would be one more intergenerational transfer.

If we raise the upper limit on that cap, that would bother me for other reasons. It would also be done neutral intergenerationally. It would raise the problem of raising the cost without increasing the benefits proportionately, and that is counter to the philosophic un-

derpinning of social security. And it would also preempt that money which has, I think, some other purposes.

For example, there is a proposal to make the whole FICA tax structure more progressive by disregarding the first \$1,000 of income, not charging FICA taxes on it. That is an idea that has been floating around. It would help a lot. It would help provide an incentive to get off of welfare and on to work at the margin, at those lower levels of income, because welfare recipients contemplating work are facing the highest tax rates in America today. And that would ease that problem.

So I would hate to see that money preempted by using the upper limit cap. But if you can come up with a scheme which is generationally neutral, then I would be very interested in looking at it.

And if, as you say, people are now spending twice as much on medigap insurance as you would ask them to pay here, it seems to me we could not use any of the FICA money, but instead strictly finance it on the premium "pay-as-you-go" basis, and it would still be a good bargain for people. That to me would be better—from what I understand you to say, that would be an even more interesting proposal.

So thank you for your suggestions.

Mr. PEPPER. I thank the able gentleman for what he has said.

I thoroughly agree with him. Our intention is that this is a pay-as-you-go. We pay for what we get. We are not deferring it to future generations, we are not adding to the deficit, we are not adding to the debt. We simply want to make it a sound fiscal program. And if we have not wisely provided that, then I would ask you, out of your expertise as members of the Ways and Means Committee, fix the tax system so it will be sound. We want it to pay its way. We estimate now—I say to my friend, we may be in error—we estimate that what the beneficiaries of this program would pay in would substantially provide the money. And we only have to take a raise in that \$43,000 as an alternative to be sure that there would be enough money to cover the cost of the program.

I thank you very much.

Chairman STARK. Mr. Daub.

I mean Mr. Gregg. I am sorry.

Mr. GREGG. Senator, I would like to follow up on what Mr. Moody was just talking about, which I agree with completely, which is that we should not have intergenerational transfers. We already have enough of that in the Social Security area.

Do you have a figure for how much it would cost to finance all this with premiums, as opposed to lifting the cap?

Mr. PEPPER. We estimate that the premiums that would be paid would equal the cost of the program. In addition, you understand, that what is now going into the Medicare program.

Mr. GREGG. Well, I understood you had an additional source of funding, so maybe I am out of line.

Mr. PEPPER. We would add the beneficiaries, they would add to the contribution they are now making. But they would also get an enormous return on their investment.

Mr. GREGG. Am I wrong in saying that you have two funding sources here? One is to lift the cap, and the other is to have an increase in the premium?

Mr. PEPPER. That is right.

Mr. GREGG. If you did not lift the cap——

Mr. PEPPER. We anticipate that the increase in the premium would meet the cost. But if it is necessary to raise funds beyond that, then we would raise the cap on the \$43,000. But we do not anticipate that will be necessary.

Now, you can make a study of it. We are going to have a study at the Congressional Budget Office available soon that will go into the details.

Mr. GREGG. And you think that figure is going to be \$70?

Mr. PEPPER. Well, you see, we estimate that the elderly are now paying about \$1,500 a year on an average for Medigap insurance and for their medical expenses. Now, we would have them pay an amount not to exceed about \$800 a year which would take care of everything. They would not need any more medigap insurance, they would not have any doctor bills, drug bills, eyeglasses bills, and all that.

Mr. GREGG. Well, medigap insurance generally does not cover long-term care.

Mr. PEPPER. Oh, yes, we cover hospitals, nursing homes, home care, as well as drugs, and eyeglasses and hearing aids and dental care and foot care.

Mr. GREGG. I understand that.

Mr. PEPPER. We emphasize nursing home care. That is one of the greatest problems that our elderly have to pay, the Alzheimer's and Parkinson's victims, the cancer victims, and so on.

Mr. GREGG. I understand that. But I guess my concern is that with your \$70 premium estimate, which would replace what people now spend on medigap. Medigap does not now cover long-term care. So how do you presume that \$70, which today is not covering long-term care, is, under your plan, going to be able to pick up the costs of long-term care, which are fairly high?

Mr. PEPPER. I know that. But the elderly people are still paying a considerable sum every month for medigap insurance, and that is the tragedy of it. It does not cover long-term care and these other expenses. In other words, they are not getting the coverage from the medigap insurance to give them the protection they need. So now we want to save them that amount of money that they so desperately need by trying to provide for the deficiency in what Medicare and medigap provides. They would not have any of those expenses. They would not have insurance expenses; they would not have doctor's bills or hospital bills or nursing home bills, or home care bills, or the like.

Mr. GREGG. I look forward, as I am sure that other members of the committee do, to getting these figures when you have a chance to reflect how much money you are going to be able to generate from this premium and how much it is going to cost to maintain this program.

Mr. PEPPER. Let me just add this to my friend. One of the things we rely upon to save money is to try to use private providers as much as possible, to get the maximum private enterprise efficiency,

and their excellent administration of the program. We think we can save a good little bit of money that way.

Mr. GREGG. I thank you.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Thank you, Mr. Chairman.

Senator, I very much admire the thrust of your testimony. There are serious questions referred to here, those of cost, and those of effective control of use, and we will have to go into those.

If I may, though, make just a brief comment, one to my friend from Washington, about the new enterprises that are undertaken in America without coverage of health for their employees.

I think there is a responsibility there that should not be shirked. Secondly, just a brief comment on generations.

This is a serious issue. However, I think we should also acknowledge that major beneficiaries of Medicare have been the children of elderly. People in my generation have been major beneficiaries of Medicare because our parents were able to have the security of health care they could not otherwise afford, and did not need to ask their children, as my parents' generation were asked, to provide the money for the care of their parents.

We welcome you here, and we will try to live up to your example. We will try.

Thank you.

Mr. PEPPER. Thank you. May I just add this.

I heard the other day that the Chrysler Motor Co. is adding \$600 to the cost of each car in order to pay for the health insurance that they provide for their employees. So we are already spending a lot of money. We are trying to spend it wisely, in a little bit more coordinated manner than the way we tried to set up in this Medicare bill of ours.

Mr. LEVIN. Chrysler has also been trying to reduce that cost by some effective cost control with some success.

Chairman STARK. Mr. Pickle.

Mr. PICKLE. Well, thank you, Mr. Chairman.

I want to welcome my distinguished friend from Florida to this committee. You and I have introduced over the years several different Pickle-Pepper bills. [Laughter.]

And I always hope that I can join again on another package. The thought comes to mind now, have you talked to Senator Heinz about this? We might invite him. [Laughter.]

Senator, it is a joy to have you here. You are the noblest Roman of them all. And each year you seem to get more progressive and challenge us more, and we love you for it. Now, that does not mean that we always agree with you. [Laughter.]

You are a marvel, and we are delighted to have you here.

I make one primary observation only. I have not seen your bill or read it so I want to look into it. It seems to me that you are going to finance it by increasing your premium on part C, a very sizable sum, instead of the \$4.92 that the administration proposes, you would recommend, I understand, \$50 to \$60 per month.

Now, I think that would send a lot of people to the hospital overnight than we could take care of just to get that news.

And then your other source of funding, as I understand it, would be to raise the wage base, unlimited, on Social Security, and you do not get into the business of taxing the value of a beneficiary.

Whatever source it is, I do not know whether that is enough, but it is certainly ambitious. This committee has started off on the assumption, as I understand our chairman, that we are going to try to take care of hospital costs and not, at one fell swoop take care of long term. But it is a problem that has got to be solved either this term or some other term. So it is appropriate that we look into it.

You may be overly ambitious and you may be challenging us on something that we cannot do at one fell swoop, but it is certainly interesting. I admire you for your advocacy and delighted to have you here today.

Mr. PEPPER. Well, the gentleman from Texas knows what affection I entertain for him and his dear wife, how much they have meant to me and my late wife over the years. I am mighty proud of that Pickle-Pepper combination.

Chairman STARK. Senator, thank you very much. We look forward to working with you. I hope that your staff and our staff will exchange information as we wrestle with CBO and the other number crunchers out there to see if we can get a set of figures that we can all work from because I think——

Mr. PEPPER. Mr. Chairman, I just want to leave you with one word, a word of assurance and a guarantee as a witness for the elderly and the people: do not be afraid to raise the money necessary to provide comprehensive health care, and take off of the hearts of the people of this country the fear.

Chairman STARK. Senator, my heart is pure. I just need a few votes. And if you can help me get those, I am with you. [Laughter.]

Our first panel this morning to provide, background on the Medicare catastrophic coverage issue, is the distinguished former Commissioner of the Social Security Administration, Robert Ball, and the former Chief Actuary of the Social Security Administration, Robert Myers. Both of these gentlemen have served this country with great distinction in an administration of the social security system which is held in the highest esteem by everyone in this country and abroad.

Gentlemen, welcome to the committee. It is a pleasure to have you both here.

Your prepared testimony will be made part of the record, and I would invite you to summarize, expand on it, and present your views to the committee in any manner that you are comfortable.

Commissioner Ball, proceed.

STATEMENT OF ROBERT M. BALL, FORMER COMMISSIONER OF SOCIAL SECURITY

Mr. BALL. Thank you very much, Mr. Chairman.

It certainly feels good to have the opportunity to testify in favor of some bills. It has been a long time. It seems to me I have been spending recent years mostly to arguing against proposals to cut back. And I thank you for this opportunity. I thank Secretary Bowen for this opportunity.

Chairman STARK. It is kind of fun, is it not?

Mr. BALL. Yes. It is a wonderful change. And I certainly want to congratulate you and Mr. Gradison and Chairman Rostenkowski and Mr. Duncan and the other members of the Ways and Means Committee who have put together these two bills. They provide for very important improvements in the protection provided by Medicare and, in my judgment, are considerably superior to the administration's proposal, both in the benefits provided and in the method of financing.

Now, the committee is fully aware that the bills do not address the problem of catastrophic care for the whole population nor some of the most important parts of catastrophic care for the elderly and the disabled. And I am fully appreciative of the dilemma that you are facing.

This is a great opportunity. The country has been alerted to this problem by Secretary Bowen's report to the President and the President's acceptance of the goal of catastrophic coverage. It is probably the best opportunity in 20 years to make major improvements in Medicare. At the same time, the proposals for change certainly have to be revenue neutral, and you have the usual problem of judging how far you can go without losing the chance to get the improvements that are possible.

I think all of us who are interested in the expansion and improvement of health benefits have an obligation to recognize the situation, and to realize that these bills should be judged as Medicare-improvement bills and not against some absolute standard of what is the best possible thing to do for health insurance coverage for the whole population, or even the best thing to do for catastrophic coverage for the elderly and disabled. The issue is to determine what is practical, what can be financed, and how can we proceed this year with something that deserves enthusiastic support across the country.

Now, I believe, the Stark-Gradison proposal for financing is superior to the administration's proposal of a flat premium which applies to everybody and where 40 percent of the financing comes from those with incomes under \$10,000—that is providing the lower income people feel that they can afford to join what is a voluntary plan and take the coverage.

But, at the same time, Mr. Chairman, I think it is clear that taxing half of the actuarial value of Medicare benefits in part A and taxing three-fourths of the actuarial value in part B does fall heavily on some middle income to low income people. Some 35 percent of the elderly will be subject to the tax. I think it would be helpful in gaining acceptance of this method of financing, which seems to me desirable, to make sure that there are benefit improvements in this package that are at least a net gain for most of the group who will be paying the cost.

I am hopeful that the committee in markup will consider some benefit improvements that would meet that test.

Another thing that I think would help gain acceptance for this method of financing would be if you provided that the income from the tax on part B benefits be dedicated to the part B trust fund—

Chairman STARK. Could I—maybe I cannot quite catch up there.

If in fact the seniors are paying a percentage of the actuarial benefit, are they not, by definition, getting more than they are paying for, or am I missing something?

Mr. BALL. Well, I am talking only about how the new tax may seem to the payer, Mr. Chairman. You are correct that you are taxing only the part paid by the employer on general revenue.

But the change, I think, is nevertheless, somewhat difficult for people to accept. They are going to be asked to pay a tax on an income they have never seen. They are being asked to pay a tax on an employer's contribution toward a benefit and asked to pay a tax on a general revenue contribution toward a benefit. I am afraid what people will see is this additional tax which amounts to well over \$200—

Chairman STARK. You mean you have got to make them aware of the benefit they are getting?

Mr. BALL. Yes. And I think the new tax would be more acceptable if the additional package of benefits was clearly advantageous to at least most of the people who were going to be paying it.

I think it is a tough row to hoe, to ask people to pay a tax on income they never saw. By correct reasoning, it is a benefit; it is income to have the employer pay throughout your life toward this protection, and it is a benefit, it is income to have a subsidy from general revenue. But people may see it as a tax on income they never actually got—that does make it a problem.

But I think, too, that dedicating income from taxing the general revenue subsidy to part B to the part B trust fund would help a lot. The guarantee that what they are paying will, year after year, go to Medicare financing, would be reassuring to these taxpayers. You have done that in part A. I would urge that you do it also for part B.

Now, superficially, the Bowen proposal, backed by the administration, and the Stark-Gradison proposal for part A may look similar, but they are quite different.

The treatment of the deductible in part A is particularly important. Actually, the administration's proposal is simply a reordering of protection, and does not actually add to it. Under the administration proposal, although they limit the deductible to two a year, a deductible is required on a new admission even if within 60 days of the last discharge—a deliberalization of present law that pays for the dropping of copayments after 60 days and the dropping of the limitation on length of stays. The limitation to one deductible a year and indexing the deductible to the COLA are important improvements in Stark-Gradison, as is the \$1,000 cap in part B.

But having said all that, it seems to me we do have a problem about making clear to the country that what is possible to pass this year may not deal with some of the most important problems of catastrophic coverage.

The three areas beyond copayments and deductibles that affect the elderly the most are the physician's fees that the individual is required to pay above the Medicare determined reasonable charge; long-term care insurance, particularly nursing homes costs, and drug coverage. And these are three things that by and large the medigap policies of private insurance do not cover and Stark-Gradison does not cover.

I am reconciled to the idea that full-scale long-term care insurance is probably not on the agenda this year. But I would urge you to look to additional financing sources so as to increase the benefit package to include drug coverage and some improvements in the home health benefit.

As the DRG provision has resulted in people being dismissed from hospitals early, transition benefits for taking care of those people at home or elsewhere become very, very important. And the intermittent limitation on Medicare home health care is very much of a barrier to good transmittal care. I think this is something to be looked at.

I hope too, Mr. Chairman, that while these bills are being considered, one in Commerce and one here, I presume, that Medicaid improvements will also be considered in the Commerce Committee. The one I would stress the most is the prevention of forcing a spouse into poverty when one member of a couple has to go into a nursing home. Now, the States insist that most of the couples income and assets be used before the individual is eligible for Medicaid reimbursement.

Senator Mikulski testified before the Senate Finance Committee the other day that a couple in Maryland living on \$1,000 a month social security benefit would have to pay over \$700 for nursing home care before Medicaid would pay. Perhaps a provision in Medicaid that would, by Federal requirement, leave at least 150 percent of the poverty rate to the spouse who was not in the nursing home and, say, \$12,000 in assets would be, not generous, but a big step forward over present practice.

Mr. Chairman, I have very little more time, but I would like to stress three or four possible sources of additional income for supporting additional benefits, that is, particularly drug coverage as an additional benefit. Drug coverage would be very popular with the elderly and with those who have to pay the costs under the proposal. I was thinking of maybe an inside deductible of about \$200 and a \$2 or \$3 payment each one filled a prescription.

Many, many older people with chronic illnesses find that drug bills are one of the biggest gaps in present Medicare coverage. A source of financing that is very logical and would go automatically into part A—where I think the drug coverage should be—is an extension of coverage to the 3 million State and local employees who are not under Social Security at the present time.

As you know, about three-fourths are under, and about one-fourth are not.

The Congress recognized a few years back that the same situation for Federal employees was unfair. People who are left out gain or have a bargain in many, many instances because they can get full Medicare coverage by a maximum of 10 years of coverage. And everyone else in the system pay in over their whole careers and have to pay somewhat more for coverage because these State and local employees are getting the coverage at bargain rates.

At the same time, there are many people in State and local coverage who lose out because their jobs are not covered in their major job and do not work long enough outside to get the coverage.

Chairman STARK. It is amazing, Mr. Commissioner, how great minds run in the same direction. I intend to introduce shortly a

third bill which, in effect, might be a third title to this, would do just that. It probably will not have as many cosponsors as the Gradison bill, because there are some very parochial objections to that. But I think it is inevitable, and my concern is that money remain in the Medicare system to either pay for more benefits or to expand them and not be used just for general deficit reduction. We have a keen interest in that. And I think you will see that come later this year.

Mr. BALL. I am very glad to hear that. The \$9.2 billion over the next 5 years that CBO estimates you get from that is approximately enough for the kind of drug coverage that I described.

And then, in addition, it seems reasonable that people who smoke and drink should pay somewhat more for their health care coverage than other people. And you get, as you know, a considerable amount, around \$15 billion over 5 years, out of doubling the tobacco tax which could be used, at least for benefit improvements.

Mr. Chairman, I have spent quite a lot of time in the latter part of my statement on long-term care insurance, and on protection of people other than the elderly under a health insurance plan. But I do not think these items are on the main agenda for this hearing, and I do not want to take the time of the committee for an oral presentation on these issues.

Chairman STARK. Well, it is important, Mr. Commissioner, and I think some of us on the committee hope that, while we may not be able to provide those benefits this year, we may set the stage at least for those benefits being added in the future. Perhaps we could set the direction in which they will be financed so that we can at least influence the future course of events in your testimony. I read an article which I think you authored not so long ago, and I think it is going in the right direction. And without prolonging the discussion today, it is something that we are interested in, and appreciate your counsel.

Mr. BALL. It would be a great mistake, it seems to me, to lose this opportunity when nationwide attention is focused on this issue, not to, at least, start studying a long-term care plan. I believe long term care insurance will become a major issue in the next year or two, both politically and as a policy issue.

[The prepared statement follows:]

STATEMENT OF ROBERT M. BALL, FORMER COMMISSIONER OF SOCIAL SECURITY

Mr. Chairman and members of the committee: My name is Robert Ball. From April 1962 until March 1973 I was Commissioner of Social Security, serving under Presidents Kennedy, Johnson and Nixon. Prior to becoming Commissioner, I served for approximately 20 years in various positions in the Social Security Administration and its predecessor organization, the Social Security Board, and for the 10 years prior to becoming Commissioner I was the top civil servant engaged in the administration of Social Security. I was Commissioner of Social Security at the time of the enactment of Medicare, the establishment of the program as a going operation and was responsible for its administration from 1965 until 1973. Since leaving the government, I have continued my deep interest in Social Security and Medicare and other programs affecting the welfare of the elderly, the disabled and all low-income people. I was one of Speaker O'Neill's appointees to the National Commission on Social Security Reform which led to the Social Security Amendments of 1983.

I am appearing today entirely on my own, and the views presented in my testimony do not necessarily accord with any of the organizations with which I am associated.

THE STARK/GRADISON BILLS, H.R. 1280 AND H.R. 1281

First, I want to congratulate Chairman Stark, Mr. Gradison, Chairman Rostenkowski, Mr. Duncan and the several other members of the Ways and Means Committee who have joined together in this bi-partisan effort to improve the Medicare program.

The bills provide for important improvements in the protection provided by Medicare and are superior to the Administration's proposal both in the benefits provided and in the method of financing.

The bills do not address the problem of catastrophic health costs for the general population or even some of the important catastrophic costs facing the elderly and disabled people covered by Medicare, but, nevertheless, their passage would be a considerable step in the right direction. And, perhaps, the Committee will consider further improvements in these bills during mark-up. They are "Medicare-improvement-bills" and must be judged as such; not against an absolute standard of the best way to fill the gaps in health care protection for the elderly and disabled or, even less, by a standard of adequate protection for the entire population. We all need to take great care that a search for the best not become a barrier to improvements that are immediately possible.

At the same time, the nationwide discussion precipitated by Secretary Bowen's report to the President and the Administration's endorsement of the Bowen proposal presents the first opportunity in 20 years to make major improvements in Medicare. I hope the Congress will take full advantage of this opportunity to fill the gaps in present coverage to the extent politically possible and fiscally responsible. I hope, too, that the Congress will improve the Medicaid program at the same time and that at the end of Committee work all the pieces—Part A and Part B of Medicare and Medicaid improvements—can be put together in a single bill that will command wide support throughout the country and the Congress.

HOSPITAL INSURANCE (PART A) BENEFIT IMPROVEMENTS

The approach taken by Stark/Gradison in improving hospital insurance protection seems to me to be greatly preferred to the Administration proposal. Instead of adding a voluntary supplementary plan paid for by a new premium, Stark/Gradison adds protection for all who are covered by the basic hospital insurance plan and pays for the benefits out of the proceeds derived from the income taxing of the employer share of hospital insurance contributions, a form of income to beneficiaries on which a tax was never paid. Some day, I hope—this year if possible—Parts A and B will be combined and the entire program made compulsory. All the elderly and disabled under Medicare need this additional protection and Part B coverage, not just those who feel they can afford to pay a premium. Whether or not A and B are combined this year, it would certainly be a step backwards to put hospital insurance improvements into a voluntary supplementary plan as proposed by the Administration.

I like, too, the fact that Stark/Gradison raises the money for Part A improvements in a more progressive way than the Administration proposal. A flat premium for all who elect coverage as in the Administration plan faces lower income elderly and disabled people with the choice of either a reduction in an already low standard of living (actually lower Social Security benefits since most who elect coverage have their benefits reduced to pay the premium) or not being covered. About forty percent of the costs of the Administration's plan would be paid by elderly persons with less than \$10,000 in annual income. That is, it would be if these low-income elderly people elect to participate.

Stark/Gradison extends the concept in present law of taxing that portion of retirement benefits (including Social Security) which is not paid for by the individual's own contributions and thus not previously counted for income tax purposes. It is reasonable to expect the relatively well-off elderly to pay for improved protection under Medicare. The financing of these bills is highly progressive—only the 35 percent of the elderly with the highest incomes would be taxed at all under this proposal. And the bills avoid additional taxes on current workers.

It is true that the additional tax for some middle-income elderly and disabled will be burdensome, and I would hope that the benefits can be improved enough to make sure that there is clearly a net gain for this group. It will be difficult for elderly and disabled people to accept the idea of paying a tax on income they have never seen, that is on Medicare protection attributable to the employer's contribution and general revenue. It would be helpful in gaining acceptance for this method of financing if it could be demonstrated that the additional benefits are worth the additional payment for at least the bulk of those paying the cost. Alternatively, the new tax

could be made to apply only above a threshold, as is the case for Social Security benefits, but then it would be necessary to consider some additional source of revenue. It would also help in gaining acceptance if the income from the tax on Part B protection were dedicated to the Part B trust fund as is done in the case of Part A. The guarantee that what they are paying will go year after year to Medicare financing would be reassuring to these taxpayers who otherwise may feel themselves singled out for a special tax going into general revenues.

The benefit improvements of Stark/Gradison are considerably better than those in the Administration's proposal. Both approaches eliminate coinsurance for hospital stays of over 60 days, and both cover unlimited hospital stays, although, of course, in the Administration proposal this coverage is not automatic and requires electing the coverage and paying an additional premium.

The treatment of the deductible, however, under the two approaches is very different. The deductible for hospital insurance has risen from \$40 when the program went into effect 21 years ago to \$520 today, an increase several times as great as the increase in the income of the elderly. Stark/Gradison addresses this problem in two ways: (1) Future increases in the deductible would not rise with increases in hospital costs but would be limited to the same percentage increase as increases in the cost-of-living adjustment in Social Security benefits; and (2) Stark/Gradison would limit the number of deductible to one a year.

At the present time about seven million Medicare beneficiaries enter a hospital each year and two million of them have to pay more than one deductible. The Administration's proposal actually makes the present hospital deductible more severe by applying the deductible to each hospital admission (with a limit of two deductible a year) even though present law does not require the payment of a second deductible if the admission occurs within a 60-day period of the previous discharge. In fact, the Administration's plan saves so much money on this deliberalization of the present deductible provision that it covers the cost of providing unlimited hospital days and dropping coinsurance after the 60th day.

I hope that the Committee will be able to consider a further liberalization in the deductible provision. The \$520 figure is a considerable burden on many elderly and disabled persons entering a hospital, and it would be desirable to reduce this amount before indexing it to the cost of living. It all depends on how much financing can be made available for the improvement of Part A benefits and what priority would be assigned to this improvement such as the extension of the program to prescription drugs. In any event, the shift to indexing the deductible by cost of living and the limitation of deductible to one a year are important improvements.

Stark/Gradison also makes improvements in the skilled nursing home benefit. The bill would add 50 days more of covered care and would substantially reduce the coinsurance which people now have to pay. Under present law, the coinsurance amount for skilled nursing home care is related to the average nationwide cost of a *hospital* day (reduced somewhat by recent legislation). The result is that from days 21 through 100, the patient now has to pay \$65 for care in a skilled nursing facility, a cost which can sometimes be almost as much as the nursing facility would charge an uninsured patient. The proposal, based on the approach used under present law to set the hospital deductible, would be to set the nursing home copayment at 20 percent of the national average of the cost of a day's stay in a Medicare nursing home. This is estimated to be \$24 a day in 1988. The copayment would apply to the first seven days of care but not to any skilled nursing home days thereafter. These changes will be helpful when the eligibility conditions for the Medicare skilled nursing home benefit are liberalized. At present this provision is so restrictive and administered so restrictively, that few people qualify, and the proposed changes will have little practical effect. This year, at the very least, the requirement of a three-day hospital stay should be dropped.

Stark/Gradison would also extend the hospice benefit beyond the current limit of 210 days so that all terminally ill older Americans would have continuing access to the hospice benefit.

PHYSICIAN COVERAGE (PART B) IMPROVEMENTS

Stark/Gradison would limit covered expenditures under Part B to \$1,000 a year. The Administration's proposal has an overall cap of \$2,000 but for the Medicare beneficiaries who are hospitalized in a year it would include the Part A deductible under the cap.

FINANCING

The difference in financing between the Administration's proposal and Stark/Gradison are important. According to the Congressional Budget Office, under the Administration's proposal, all who elect the supplementary coverage will need to pay a premium of about \$77 a year in 1988. Under Stark/Gradison, 65 percent of Medicare beneficiaries, those with the lowest incomes will pay nothing additional because they will not have to pay income taxes, 26 percent (those in the 15 percent tax bracket) will pay about \$265 more, and the 8 percent in the 28 percent bracket about \$495 more. And, of course, the protection provided by Stark/Gradison is better and will be universally available. If protection under these bills can be made more attractive, this method of financing could well command wide support as part of a package which includes other revenue sources to pay for the additional protection.

REMAINING GAPS IN PROTECTION FOR THE ELDERLY

Important as it is to improve hospital insurance under Medicare, relatively few people, about 200,000 a year, are affected by the present coinsurance requirement for stays that go beyond 60 days. Many more, but still a small percentage of the elderly, about two million, are affected by having to pay the hospital deductible more than once in a single year. For those who are affected by these provisions, it is very important to prevent the catastrophic cost that can result in individual cases. With the DRG system of reimbursement creating strong incentives for early discharge from hospitals, the original reason for copayments attached to stays of longer than 60 days has disappeared. Certainly these improvements in hospital coverage should be made, but it should be recognized that hospital insurance protection under Medicare is already good protection and that the large costs for Medicare beneficiaries as a group lie elsewhere.

In 1984, the elderly had to pay out-of-pocket about \$1.7 billion for hospital care, but they paid \$29 billion a year out-of-pocket for other health services. The big gaps are in Part B, physician coverage, (arising not only from the 20 percent copayment provision but from the fact that physician are allowed to charge more than the Medicare-determined "reasonable charge"), and in the complete exclusion from coverage of certain very important items such as prescription drugs.

Another area of great concern that I will address later is the almost total lack of insurance protection—public or private—against the cost of long-term care for the seriously disabled elderly, whether cared for at home or in a nursing home. The biggest gaps in Medicare protection, in addition to deductibles and copayments—prescription drugs, nursing home care and physician charges above the "reasonable charge" determination—are seldom covered by the private insurance Medigap policies and are not covered by Stark/Gradison.

Important as the improvements in these two bills are, it is of considerable importance—in order to prevent later disillusionment—that the country understand the limited nature of what is being proposed.

CAN WE DO MORE?

I certainly hope we can do more. There are additional sources of financing that can quite logically be used to improve the Medicare program further. The most obvious is the extension of Medicare coverage to approximately three million employees of state and local governments, the one-fourth of state and local employees not currently under Social Security. This group is currently receiving an unfair advantage under the Medicare program since they can get full protection if they have a maximum of 10 years of work in a Social Security covered occupation before or after their employment by government, or by moonlighting. Just about everyone else in the country—now including Federal employees—pay toward Medicare throughout their entire careers, but this group can frequently get the protection at bargain rates, and because of this, everyone else has to pay more. On the other hand, some in the group are disadvantaged by the failure to be covered for Medicare in their state or local job since they may not work enough elsewhere to gain eligibility. In all fairness, the national program of Medicare should be extended to this one remaining excluded group.

According to CBO, the extension of coverage would increase net income to Part A of Medicare a total of \$9.2 billion over the next five years—\$1.3 billion in f.y. 1988, \$1.9 billion in 1989, \$1.9 billion in 1990, \$2.0 billion in 1991 and \$2.1 billion in 1992. This additional income could be used to finance other improvements in Part A benefits. One good candidate for improvement would be to include prescription drug cov-

erage, say after a \$200 special deductible and with a \$2 or \$3 fee per prescription. The failure of Medicare to cover prescription drugs furnished outside of an institution is now a great burden on many elderly and disabled persons with chronic illnesses, and the addition of this protection to the Stark/Gradison bills would, I am sure, be very enthusiastically received by older and disabled persons, including those required to pay additional taxes. The extension of coverage to those state and local employees now excluded would provide just about enough money to cover such a drug benefit.

Other possible sources of increased income for Medicare include increasing the tax on tobacco and alcohol. It seems reasonable to charge somewhat more for health care to people who smoke and drink. According to CBO, doubling the tax on cigarettes produces an estimated \$15.1 billion over the next five years, about \$3 billion a year. An increase in the tax on distilled spirits from \$12.50 per proof gallon to \$15 would raise about \$3 billion over five years. Even indexing the current cigarette and alcohol tax rates for inflation would raise \$4.8 billion over this period.

And if major improvements beyond Stark/Gradison are adopted, it would seem reasonable to me to have a premium increase of modest proportions for some of the improvements in Part B benefits, but I think this is a last-resort way of financing. It is better than having the cost borne by people when they get sick, as is the case with deductibles and coinsurance, but premiums cut into the income which a high proportion of the elderly need to meet the ordinary expenses of daily living.

Perhaps with some of these additional sources of financing, the \$1,000 cap in Stark/Gradison could be reduced to \$750 or \$500 and home health benefits made more useful by allowing more regular visits for longer periods. As hospitals have been discharging patients earlier, following the adoption of the DRG system of reimbursement, it has become increasingly important to improve the transition benefits for those leaving the hospital.

In time, there are other changes that should be made. The improved Medicare plan should be extended to all the disabled receiving Social Security benefits, not just those who have been receiving them for two years as under present law, and all Social Security beneficiaries should be included. Widows and child beneficiaries need the protection as much as older and disabled people.

MEDICAID IMPROVEMENTS

For the elderly, probably the harshest feature of the nursing home benefit under Medicaid is the requirement that the spouse as well as the nursing home patient be impoverished before Medicaid will pick up nursing home costs. At present, for example, a couple in Maryland, living on \$1000 per month in Social Security benefits would have to spend \$708 of that income for nursing home costs before Medicaid would pay the rest. This leaves the spouse of the nursing home patient with only \$292 to live on.

Although, the eligibility requirements vary, all states require that the couple have few assets and extremely low income. A Federal requirement protecting more of the assets and income of a couple to prevent the life-time impoverishment of the spouse of a nursing home patient should have a very high priority. It ought to be done this year. Federal law, for example, might require that the state plan allow the spouse of a nursing home patient at least 150 percent of the poverty level for a couple (less than \$10,000 a year in 1985) and \$12,000 in assets. Not very generous, perhaps, but a big improvement.

We need to take a look, too, at how to make the medically indigent provision in Medicaid mandatory and how to establish a solid Federal floor for the Medicaid income test.

LONG-TERM CARE INSURANCE

So far, in addition to Medicaid, I have talked largely about health insurance coverage of the costs of acute care. However, I believe a major emerging issue of the late 1980's will be how to provide protection against the devastating catastrophic costs that the elderly and their families face when there is need for long-term care for patients with chronic illness and disabling conditions, such as strokes and Alzheimer's disease.

The issues surrounding protection against the cost of long-term care must be dealt with in a highly unusual context. People think they already have protection, and they do not. A national survey conducted in 1985 by the American Association of Retired Persons revealed that 79 percent of the population at large and 70 percent of the population over 65 believed that Medicare would cover a long nursing home stay regardless of the type of care required, and half of those with Medicare and

supplemental insurance policies believed that they were covered for long-term care expenditures. This is not the case.

Both Medicare and the private supplements are designed to deal largely with the cost of active treatment and just do not cover the needs of the typical long-term care patient, who, by and large, does not require the services of a physician or a skilled nurse but rather help in dressing, feeding, toileting, moving from one place to another and in the case of those with mental deterioration, supervision.

Nursing home care, the most expensive part of long-term care, is hardly paid for at all by either Medicare or private insurance (less than 2 percent by Medicare, about 1 percent by private insurance). Slightly more than half is paid for by the patient or his or her relatives and the rest is paid for by Medicaid.

Most long-term care, however, is not provided in nursing homes nor by professional care-givers. Seventy percent of the people with long-term care needs live in private residences and about three-quarters of them receive all needed assistance from family and friends. Another 20 percent receive help from both professional service agencies and family and friends.

The Medicaid program, the only program that is doing much about nursing home expenditures, does not help much on home care. In most states the amount and type of home care provided by Medicaid is extremely limited although this situation is improving. Still, Medicaid-covered long-term care is received almost entirely in nursing homes.

To get Medicaid a person must either be poor or be reduced to poverty in the process of trying to pay for care. Few people can sustain independently a stay of a year or so in a nursing home and thus many of those who start out paying their own way end up on Medicaid.

There is much about long-term care that would seem to lend itself to making provision ahead of time through insurance. Any particular individual faces a relatively small probability of needing a large, costly amount of long-term care, but for the few it can be very expensive indeed. A 65 year old faces about a two in five chance of ever needing nursing home care, but for most the nursing home stays are brief. Fifty percent of admissions are for less than three months; 40 percent for less than a month. Only a small proportion of the elderly (10 percent) will stay over a year, and this group uses 90 percent of nursing home resources. The average expected nursing home cost for persons who stay for one year or longer is about \$100,000. This kind of distribution of costs would seem ideal for insurance—a large number exposed to a risk but only a small number actually having to pay a large amount.

And individual saving is not an efficient means of meeting the cost of long-term care. If each individual saves to meet a high cost which will be experienced by only a few, the majority, for no good reason, have cut back on the use of their money for some other purpose. If each individual contributed the relatively small cost of average use, the group as a whole could be insured for quite a low premium. This is what insurance is all about.

Given these circumstances, why hasn't private insurance moved in to meet these needs? There are good reasons. If sold on an individual voluntary basis, there is concern that people will wait until they are quite old and the risk of needing care is high, and indeed, this has proven to be the case for those policies that have been sold. And there is concern that if an attempt is made to cover home care, there will be great difficulty in determining who should get the care, how much and under what circumstances.

Because of these concerns, private insurance has not offered much protection. Even now, after years of study, it appears that only about 200,000 policies have been sold, with most of these being solely nursing home insurance, without the alternative of home care. The policies are on an indemnity basis, a specific dollar amount per day, with coverage limits which preclude payment for extensive stays.

Group insurance which avoids some of the problems of individual voluntary insurance does not seem to be in demand. Employers are greatly concerned about the cost of the supplements to Medicare (mostly acute care) that they are already committed to pay and are more interested in cutting back than expanding. And the unions have not pressed for this type of group coverage.

It is true that several major insurance companies are now active in designing new approaches to long-term care insurance, and undoubtedly some worthwhile protection will be offered, but it is doubtful that widespread private coverage will result. And the Administration's proposal to establish another tax expenditure program to encourage people to save for the costs of long-term care would not meet the need for the average worker. By now, we know pretty well that it is the relatively well off who take advantage of these IRA type savings plans, and yet all taxpayers bear the cost of foregone revenues.

The Treasury analysis of 1983 returns shows this to be true of IRA's established by taxpayers in various total income classes (that is, gross income before losses). Sixty-four percent of tax returns with total income in excess of \$100,000 included a deduction for IRA's, compared to 6 percent with return below \$30,000. In a special report in Tax Notes for June 2, 1986, Harvey Galper and Charles Byce conclude that "The IRA may be intended to help wage-earners save, but the 1983 data shows that it enables those who already have wealth to use it to greater tax advantage."

Given this background, the issues in long-term care policy that emerge most importantly are:

(1) Should we undertake long-term care insurance as part of our Social Security system, probably as an addition to Medicare? Spreading the risk to everyone on a compulsory basis and having the payments made by all current workers would make the individual premiums quite low, perhaps in the neighborhood of a half percent of payroll for the employee and a half percent for the employer for the kind of plan described below. And to some extent even this cost would be offset in the national accounts by lower Medicaid expenditures by the Federal and state governments. Today over 40 percent of Medicaid expenditures go to meet the nursing home costs of elderly people.

(2) Is private indemnity nursing home insurance a desirable or undesirable development? Many feel that if a plan covers only nursing home care, elderly people will be institutionalized unnecessarily and that this will be to their disadvantage and may increase costs. Yet this has been the general, although not exclusive, direction that private insurance has taken.

(3) How can the cost of government plans be kept low and still meet the most important part of the need? Perhaps by:

(a) Covering only the seriously disabled, say those who need help with two or more of the "activities of daily living."

(b) Requiring a waiting period (say three months of serious disability) before there is reimbursement.

(c) Administering the home health benefits through organizations that are at risk by reason of being paid a per capita amount, who work with the elderly person and his family on providing appropriate care and who have the authority to transfer an individual to a nursing home when that is judged less expensive—in other words, the provision of services through a managed care system.

(d) The object would be to design a plan that protects assets but does not add to those assets by paying the room and board costs of a nursing home and letting Social Security and pension plan income accumulate. It seems that in this area of insurance a waiting period deductible plus a copayment for home health care and an even larger copayment when one enters a nursing home (and there is no longer need to maintain a home in the community) might meet a large part of the need at relatively low cost. After all, Social Security and pensions are supposed to meet current living costs, not add to an estate.

The major alternative to a compulsory public insurance program is an expanded means-tested Medicaid program covering home health benefits. This is likely to prove unsatisfactory for most elderly people and their families, and as the population ages the burden on states of financing adequate care will crowd out other state services and create major problems for state governments.

Thus the big issue is the feasibility and desirability of a Federal long-term care insurance plan. I believe this will be an important public policy and political issue, perhaps within a year or two.

I expect the support for this type of protection to come not just from elderly people themselves but also from their sons and daughters. The strongest pressure may well be from middle-income and middle-aged people. Many such families today are faced with the poignant choice of either taking an elderly person needing care into their own homes, with consequent disruption to the careers of a two-earner couple, and the loss of time and money for children, or on the other hand, having a parent go into a Medicaid nursing home, frequently against the wishes of the parent. A national system which can ease some of the burden on the family through home care benefits, or alternatively, together with Social Security and retirement income, pay the cost, if needed, of nursing home care, will, I believe, become very attractive as more and more people become aware of their present lack of protection.

We need to start now to study how to provide public long-term care insurance in the most cost effective way and in a way that is best for elderly people and their families.

WE NEED A HEALTH PLAN FOR ALL AGE GROUPS

It is important to make clear that the problems of the elderly and disabled in securing quality care at an affordable price are not unique. Other age groups have as serious, or in some instances more serious, problems, and we need to address those problems, too, as soon as possible. Perhaps all that is possible this year are Medicare—improvement bills with some modest changes in Medicaid, but the need for a health plan for all should have high priority on the national agenda.

The view is put forward by some that private group health insurance tied to the job is taking care of the financial problem of meeting health care costs for workers and their families and that any residual problem is being taken care of by the Federal-state Medicaid program for low-income people. This is not the case. Group health insurance for workers is widespread, but many in low-paying or part-time jobs or who work for small employers are not covered. And things are getting worse, not better. Between 1978 and 1984 the number of persons without any health insurance has increased from 28 million to more than 37 million. Since just about all the elderly have Medicare coverage, this growth in the number of uninsured is among those under 65. And added to these uninsured are some 10 million who have insurance that is so limited in scope that they go without needed care or are faced with medical and hospital bills of catastrophic proportion.

In the recession of 1981–82 when the unemployment rate went up to 10 percent, growth in the uninsured population rose quickly because private health insurance protection is largely dependent on having a job. This is not surprising, but what is surprising is that health insurance coverage has not increased during the recovery. The great majority of those without insurance live in households where there is at least one worker, although, of course, being out of a job continues to be an important cause of being without protection. Under present arrangements, if we face another recession in the next several years, the number of uninsured could easily rise to 50 million.

The vaunted safety net of the means-tested Medicaid program is full of holes—not just for the elderly but for people of all ages. To more than half the people living below the rock-bottom level of officially defined poverty (\$10,989 for a family of four in 1985), the Medicaid program is not available.

One still might think that even in the absence of health insurance and Medicaid coverage, people in America in one way or another get the care they need—perhaps through public hospitals and the generosity of private physicians. To some extent, yes, and to some extent, no. The differences between the amount of health care actually received by the insured population and the uninsured is very striking and documented in numerous studies. People without insurance tend not to seek care when they need it. Much more often than other people they are denied care for economic reasons, and such care as they do get is, in many cases, provided under conditions in which good quality and continuity of care are unlikely.

We are the only industrialized nation in the world that has no system for assuring health care for all. Consequences are unforgivably harsh. For example, many high-risk pregnant women are going without the care they should have and infants are being exposed to permanent damage. We are getting farther from, not closer to, the goal of providing all our citizens with the essentials of adequate care regardless of individual ability to pay.

For several years now the public policy emphasis has been on cost control. The push has been for more and more competition and corporate intervention to control costs. And cost control is important. But so is quality care available to all. The public is certainly not content with the present situation. As Dr. Arnold Relman, the editor of the prestigious *New England Journal of Medicine*, writes in a remarkable editorial in the December 18, 1986 issue of the *Journal*:

"Polls have always shown a strong public preference for a universal health insurance system over the malfunctioning patch-work arrangement we have lived with since the mid-1960's. A recent referendum question on the Massachusetts state ballot asked voters whether the state government should urge the U.S. Congress to enact a national health program that would be 'universal in coverage, community controlled, rationally organized, equitably financed, with no out-of-pocket charges . . . and efficient in containing its cost . . .'. Two-thirds of the voters responded in the affirmative."

He goes on to say:

"Perhaps even the medical profession, disenchanted with the private corporations and the competitive market, will some day be leading the campaign for a publicly financed alternative."

I think it is very likely that such a national health insurance system controlled by national budgets would in the long term cost no more than would the continued growth of our present largely chaotic combination of private and public insurance, means-tested programs for the poor and publicly operated hospitals for the low-income population. I believe we should adopt such a system as soon as possible.

CONCLUSION

We need to move forward to improve health insurance protection for all. Perhaps in a piecemeal fashion this year—wherever it is feasible—but we need to move. We are the only country in the world that spends as much as 11 percent of its gross national product on health care, and we are the only industrialized country in the world that does not guarantee health care for all its citizens. Most disgracefully, we are the only industrialized country in the world that forces many of those with low incomes who get sick either to do without health care or to beg for charity.

Chairman STARK. Mr. Myers.

STATEMENT OF ROBERT J. MYERS, FORMER CHIEF ACTUARY OF THE SOCIAL SECURITY ADMINISTRATION

Mr. MYERS. Thank you, Mr. Chairman.

The basic principle of any insurance is to protect people against losses which they cannot readily bear out of their own pockets. From this standpoint, catastrophic protection under Medicare is desirable. Perhaps Medicare is even too much first-dollar protection than it ought to be.

I realize, of course, that the medigap policies have provided catastrophic protection. Many medigap policies are, I think, administered at relatively reasonable expenses, although this cannot by any means be said of all such policies.

On the whole, I agree with the benefit design in the Stark/Gradyson bill. I believe that any changes made should be consistently done for Medicare for all persons covered and should not be done on a voluntary or individual choice as is. I have been advocating that for some time.

I think that there is one serious loophole contained in this bill that I would hope the committee would remedy. The taxation of the hospital insurance benefits is based on people being entitled to the benefits, not on the basis of being eligible. Here is what can happen. Consider a high paid individual who reaches age 65 and continues in employment. Currently, that individual does not file for cash benefits, but does file for the hospital insurance benefits. If this provision is the way that it is now, such persons will not file for the hospital insurance benefits until they are hospitalized. Because to be "entitled" means that one must have filed a claim—that is having filed income for protection. The way to get around the income taxation of 50 percent of the value of the HI benefit protection is that the person would not become "entitled" until actually entering the hospital, maybe a year or two later after attaining age 65. So the income taxation basis should be on the basis of eligibility for benefits, not entitlement.

Chairman STARK. I suspect that is what we intended. It is conceivable that somebody could not enroll in part B, which is voluntary and not be taxed on that. But we anticipate that would be a pretty small number of beneficiaries. But I appreciate your concern.

Mr. MYERS. As to part A, people can wait to become entitled until they are hospitalized. In fact, there is a retroactive period of 6 months possible. So, nobody would file for HI until they needed it for a hospital episode, although they really had that protection all along.

There is one mistake in my testimony, because the draft bill that I had was not complete. This is in regard to a provision that the Treasury Department will report how it estimated the additional income taxes due taxing 50 percent of the actual value of the HI protection. That provision is quite proper and correct in the bill, although I would suggest to the subcommittee that it should be tightened up, because the provision states that the Treasury Department will report annually, and it does not say when. There is a provision in present law for the cash benefits which is like that. However, Treasury has not yet submitted the annual report for 1984.

I agree with Mr. Ball that the proceeds of the income taxation on the part B premiums should flow into the SMI trust fund. Otherwise, this affects the financing, and likewise the premium rate itself.

As to the HI deductible, I understand the appeal and logic of indexing it by just the straight CPI instead of a medical CPI, but I still would prefer the present procedure of indexing this deductible by some cost of hospital care cost index.

Also, I suggest that, instead of a one-time initial deductible, it might be better to have it on the basis of so much per day for 10 days. In other words, instead of \$520 the day you enter the hospital, it might be better to have, say, \$60 a day for each of the first 10 days. This would be some encouragement for people to leave the hospital. As it is now, there is no inducement to do so.

Chairman STARK. I do not know anybody who looks forward to a long stay.

Mr. MYERS. But there are many people who will stay in an extra day or two that they might not if it saved them some money.

Chairman STARK. But that is at the end?

Mr. MYERS. Yes. That is why I would say \$60 a day for 10 days. Then if on the seventh day, you are ready to leave, you have an incentive to not spend an extra day, because you can save the \$60 by leaving promptly.

As to the coinsurance for the hospital benefits, drawing your attention to the history, originally hospital benefits were paid for only 90 days. I did not like such a limit at the time that Medicare was enacted because I believe in catastrophic coverage. It was done, I think, for the wrong reason—namely, some planners said that nobody needed to be in the hospital for more than 90 days and that there would be abuse of the system if benefits were paid for a longer period. I think that there are other ways of curing overuse abuse than through severe monetary restraints, and I am glad to see the approach in the bill.

As to the skilled nursing facility benefits, the bill intends to have coinsurance up front, I suggest that this may be undesirable. People would not be likely to want to move from the hospital—where they are not having any coinsurance to a skilled nursing facility where they would have immediate co-insurance. The ap-

proach in present law is correct—namely, that there is no daily coinsurance for the first 20 days, but after that there is some. Perhaps there should not be as much coinsurance as in present law. Perhaps, it should not go on for 80 days. But I am afraid that people will not want to leave the hospital to go to a skilled nursing facility, because they will say that immediately they will have to start paying \$24 a day or something like that for the first 7 days.

One other thing that I would strongly urge the subcommittee to do that—was a mistake from the beginning—is in connection with the initial deductible under part B—now, \$75 per year—this amount is not indexed. It seems to me that, if all the other cost-sharing elements of the program, like the catastrophic cap and so forth, are indexed, so too should be the \$75 initial deductible, and it should rise in the same way as all the others.

My last technical point is in connection with the determination of part B premium. The bill does not touch that provision. It is a difficult matter, as the subcommittee knows from wrestling with it. I would hope that the matter would be settled as to just how the part B premium is to be determined in the future. If it is to be continued as it is now, by increasing it no more percentagewise than the cash-benefit increase, I suggest that the premium promulgation date should be moved up 1 month. The way that it is now, the premium has to be determined in September, and you then have to look back at the increase in the cash benefits of the previous year. There is a 1-year lag there that just is not necessary.

If the SMI premium were determined in October, it would be known then just how much the cash benefits would go up next January, and the whole thing would be in sync.

Finally, Mr. Chairman, as to long-term nursing home care, I address this in my testimony. I do not believe that there can be—as serious as the problem is—long-term nursing home care benefits on an insurance basis. I believe that the solution to this problem is through a revised Medicaid program that is liberalized in some ways—as, for example, by not requiring people to spend down their assets, but rather being allowed to maintain their assets as long as the couple lives—but then with stronger provisions for recovery of this money by the Government, and for prevention of transfer of the money to other people in anticipation of the need for skilled nursing home care.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT BY ROBERT J. MYERS PRESENTED TO THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON WAYS AND MEANS, HOUSE OF REPRESENTATIVES, MARCH 5, 1987, WITH REGARD TO EXPANDING MEDICARE TO INCLUDE CATASTROPHIC COVERAGE

Mr. Chairman and Members of the Subcommittee: My name is Robert J. Myers. I served in various actuarial capacities with the Social Security Administration and its predecessor agencies during 1934-70, being Chief Actuary for the last 23 of those years. In 1981-82, I was Deputy Commissioner of Social Security, and in 1982-83, I was Executive Director of the National Commission on Social Security Reform.

The basic purpose of any type of insurance plan, including Medicare, should be to protect individuals against financial losses which they cannot readily bear out of pocket. For this reason, emphasis should be placed on reimbursement of catastrophic losses, rather than first-dollar outlays. Unfortunately, however, many people want the latter type of coverage so as to "see some return on their premium dollars", especially for unwelcome expenditures like medical-care costs that do not involve pleasant experiences.

For this reason, I enthusiastically support the basic intent of the two bills introduced by the distinguished chairman and the ranking member of this Subcommittee and the chairman and the ranking member of the Committee on Ways and Means -- as well also as the proposal of the Reagan Administration. However, I recognize that a considerable part of this problem is now being handled by Medigap policies, many of which (but by no means all) operate at reasonable administrative expense.

I would like to turn back to the early history of the Medicare program, so as to explain why certain features were adopted. A maximum was established on the number of hospital days for which benefits are paid because it was thought that extremely long stays were rarely necessary, and that this financial "stick" was necessary to prevent extreme malingering. Because of my belief in the catastrophic element of insurance, I never liked this approach. Instead, other measures, such as utilization review, should remedy any problems of malingering, and certainly some legitimate cases of long stays do occur, and should be protected.

The basis of having no daily coinsurance for the first 20 days of Skilled-Nursing-Facility benefits was logically adopted so as to eliminate any immediate financial disincentive for persons to transfer from high-cost hospitals to low cost SNFs.

Indexing of the HI cost-sharing provisions was provided, and this was extremely logical in recognizing the likely changing value of the dollar over the long future and the necessity for maintaining their values. A mistake was made in that such indexing was not also done with regard to the initial deductible under the Supplementary Medical Insurance program.

The proposed changes in the two bills presently being considered to provide catastrophic protection very desirably do so uniformly for all covered persons. It would be a serious mistake if the catastrophic protection were merely an option that some persons could take, and others could refuse. Having various options is quite desirable for individual insurance plans, where representatives can adequately explain the choices available. However, in a large nationwide plan with millions of covered persons, it is impossible to explain adequately any elective choices available to the many persons who have relatively little knowledge of the subject.

As to the income taxation of the value of the Medicare protection, I enthusiastically support the provisions of the bill which contains this provision. If the Social Security cash benefits are to be subject to income tax,

it is only logical that this should also apply to the Medicare benefit protection. If I might immodestly say, I believe that I was the first person to propose the general procedure as contained in the bills. This was done in an article, "A New (but Only Partial) Solution to the Medicare Financing Problem", in the Fall 1984 issue of Health Affairs (Vol 3, No.3), published by Project HOPE, Millwood, VA.

Further with regard to the income taxation of the value of Medicare benefits, I believe that the bill has several significant technical and policy weaknesses.

First, only the value of the HI protection ostensibly due to the employer portion of the HI tax is taxable only for persons entitled to HI benefits as a result of an earnings record (i.e., are eligible as a result of insured status and having filed for HI benefits). A huge loophole is present! Highly-paid persons who are working when they reach age 65 -- and who now can, and generally do, file for HI but not for Social Security cash benefits -- will not file for HI, and so will avoid income taxes on the value of HI benefit protection. And such action will not make them lose any HI benefits, because when (and if) they are hospitalized, they can then file for HI (even retroactive filing for 6 months is possible).

Second, the bill does not seem to require that the income taxes on the value of the SMI benefit protection coming from the Government contribution should go into the SMI Trust Fund (as is properly done for the appropriate portion of the income taxes on the value of the HI benefit protection, which goes into the HI Trust Fund). At first glance, this might seem to be immaterial because such a large proportion of the cost of SMI comes from the General Fund of the Treasury, to which income-tax receipts go, unless otherwise provided. However, such non-transfer of the income-tax receipts on the portion of the total SMI premium coming from the General Fund would affect adversely both the financial situation of the SMI Trust Fund as it is changed by the enhanced benefits and the premium rates to be charged later to the enrollees.

Third, the determination of the amount of the "imputed Medicare Part B actuarial value" is not clear for those cases where the individual pays a surcharge for late enrollment and where, as in 1984-88, the premium rate is subject to special limitations. I believe that, for simplicity, the basis should uniformly be (a) twice the actuarial rate, minus (b) the standard premium rate.

Fourth, a requirement should be added that the Secretary of the Treasury should report annually as to the past and expected future operations of the income-tax provisions and on the methodology used in determining the actual transfers. Such procedure is provided for in the Social Security cash-benefits program -- in Section 121(e)(4) of the Social Security Amendments of 1983 (P.L. 98-21).

Now turning to the Hospital Insurance provisions, the change to eliminate any maximum duration of benefits and to have a single annual deductible is well in line with the insurance principle of catastrophic protection. I suggest, however, that it would be preferable to have daily coinsurance for, say, 10 days per year in lieu of a single deductible, so as to provide some financial encouragement to shorten hospital stays; if this were to be applicable in 1987, the actuarially equivalent daily coinsurance to the \$520 initial deductible would be about \$60.

The bill provides a new procedure for determining the voluntary HI premium rate for the relatively few people who are covered on this basis. The procedure would be the same as that which has been used for the SMI premiums -- an actuarial estimate of the likely incurred cost involved. More importantly, such actuarial rate would be used as the basis for the income taxation of the value of HI benefits. I strongly support this approach. I suggest that it should be required that the annual Trustees Reports should make a comparison of the actual experience (when it is available) with the estimate used to determine such rate.

As to the Skilled Nursing Facility benefits, I agree with the extension of the benefit period from 100 days to 150 days. Again, this recognizes the catastrophic principle in insurance for the very few cases that would go beyond 100 days for this limited benefit. However, I believe that changing the basis of the coinsurance so that it applies for only the first 7 days and at a rate of 20% of the estimated nationwide average daily cost will have unfavorable cost effects. Serious financial incentives are involved, because hospitalized individuals, who have no daily cost sharing, would be reluctant to transfer to the lower-cost SNF, because it would mean more out-of-pocket expenses for them. I suggest that the daily cost-sharing basis for SNF benefits should continue to apply only after the 20th day, and perhaps only up through the 60th day, and at a rate of perhaps 40% (rather than 20%) of the estimated nationwide average daily cost.

I am in full agreement with the changes made in the blood-deductible and hospice-care provisions.

The indexing of the HI inpatient hospital deductible would be changed by the bill so as to be on the same basis as the Social Security cash benefits -- i.e., based on changes in the general CPI. Although I can see the logic and the appeal for this basis of indexing, I believe nonetheless that the basis should be through the use of some medical-care cost index. As a technical point, the promulgation of the inpatient hospital deductible, after the prescribed indexing, is required to be "not later than November 15" of the preceding year. This conforms with the similar provision for the Social Security cash benefits. However, as a practical matter, the law requires the promulgation to be not later than October 30 (when the Congress must be informed), so I suggest using such date. In any event, because the CPI for September (the last one needed for the computation) is available about a week before the end of October, the date of October 30 is quite feasible. In fact, any informed person can readily make the calculation once the September CPI is available.

Next, as to the Supplementary Medical Insurance provisions, the introduction of a \$1,000 catastrophic limit in 1988 on out-of-pocket expenses for medical expenses covered by SMI is in accord with the catastrophic principle of insurance. Quite logically -- and even necessarily -- the limit would be indexed for future years. The indexing would, consistently, be done on the basis of the cost-of-living adjustment in Social Security cash benefits, but I believe that it would be preferable to base the indexing on medical-care costs. The same technical point as to the promulgation of this limit applies as in connection with the HI inpatient deductible.

Perhaps the most important suggestion that I have to make as to the SMI program is in connection with the \$75 annual deductible. Considering every other change that would be made by the bill, it is only logical that this deductible should also be indexed. To allow it to remain unchanged at \$75 for all future years is not equitable or reasonable. I urge the Subcommittee to make this change.

One issue which is not addressed in the bill is the perplexing one of the determination of the SMI premium rate in the future. I believe that this issue should be settled once and for all. It is my conviction that the premium rate should be a uniform proportion of the total per capita cost of the program, regardless of whether the Social Security cash benefits change at the same rate as the SMI premium rate. For 1984-88, this proportion has been set at 25%. Certainly, this would be a reasonable basis to continue indefinitely into the future, although I really favor a somewhat higher proportion, such as 35% or 40% (which contrasts with the 50% initially contemplated in the 1965 Act). If such an increase in the proportion were to be enacted, it should go into effect very gradually, such as by a rise of 1 or 2 percentage points each year.

Another change should be made with regard to the determination of the SMI standard enrollee premium rate if it continues to be determined, at least in part, from the increase in the CPI as used to compute the cost-of-living adjustments for Social Security cash benefits. Under present law, the promulgation of the premium rate for a particular year must be made in the preceding September. As a result, the CPI increase used dates back to the preceding year's situation and thus is both inconsistent and out of date. I suggest that the promulgation date should be the same as for other elements of the Medicare program -- on or before October 30, preferably. This is quite feasible, both actuarially and administratively.

At present, the law has certain inconsistencies with regard to the requirements for the actuarial estimates for the Social Security cash-benefits program and for the two parts of the Medicare program, as presented in the annual Trustees Reports. For example, detailed year-by-year estimates for the next 5 years are required for the Social Security program, but only for 3 years for HI and SMI. I believe that such figures should be prepared for the next 5 years for all programs, and that 75-year projections should be similarly be made in each case. Also, the underlying estimates for the HI deductible, the SMI maximum out-of-pocket limit, and the SMI premium rate over the years should be presented.

The bills deal only with catastrophic coverage for the types of medical services now covered by Medicare. As the distinguished chairman has pointed out, they do not deal with the very serious problem faced by senior citizens with regard to the costs of long-term nursing-home care.

Let me conclude my testimony by briefly discussing this issue. There is no question but that this is an extremely serious matter. I am convinced that the solution does not lie in providing benefits for such care on an "insurance" basis under Medicare. I believe that benefits of such a nature are not an insurable risk, because in many cases they would substitute domiciliary care in a high-cost establishment for subsistence in a private home that might be of an inferior quality or for care by relatives who would be greatly inconvenienced in providing it. The only way that an insurance basis would be at all feasible would be if there were relatively high cost-sharing -- but this would negate, to a considerable extent, the value of the benefit for low and moderate-income persons.

In my opinion, the solution to the problem of the financial burdens of long-term nursing care is to provide it under a restructured Medicaid program. The requirement of spending down assets would be eliminated during the lifetime of the individual and his/her spouse. Instead, a lien would be imposed on the assets (including the home) after the death of both spouses (or the individual, in the case of unmarried persons). In addition, strict provisions would be established so as to prevent the transfer of assets to the children or other persons during (and also in anticipation of) the nursing-home care.

Chairman STARK. Thank you very much.

Mr. Coyne.

Mr. COYNE. I have no questions.

Chairman STARK. I have a couple of questions, if I may just very quickly.

On the last topic that Mr. Myers raised, it occurs to me that one quick fix on the Medicaid qualification would be the treatment of the asset of a home.

Our preliminary figures show that some 70 percent of the 30 million seniors own a home. And the idea of losing that to spend down could be frightening to a couple.

Once a person enters into what is a permanent stay for the rest of their life—a rest home, nursing home or care program—the children may be concerned about keeping the home, but the surviving spouse probably is not. And if we worked out some kind of a system to split the equity, and spend down half the equity for each person, we might solve that problem.

And, second, I would ask the witnesses what their thought would be about—we tried this some years ago in terms of annuitizing the equity, perhaps having some kind of FHA insurance that would insure the lender or the facilitator. They could get \$125,000 tax free out of their house now, and deduct the payments basically as they accrue that equity in their lifetime. It seems to me that is what Secretary Bowen is talking about. It is there. All we really have to do is find a way for people to use up that equity judiciously and not make the surviving or the healthy spouse destitute in caring for the other.

I wonder if either of you have any comments or have thought that through?

Mr. Ball, Mr. Myers.

Mr. MYERS. I concur completely with you, Mr. Chairman, on that. I think that this approach of annuitizing the home is an excellent one. I do not think that it can be compelled, but it should be encouraged as much as possible. And I think I would even go further, Mr. Chairman.

Chairman STARK. Well, we do compel them to do so in the Medicaid program. Now, we compel them to get rid of it or they do not qualify and——

Mr. MYERS. I would go further than you, Mr. Chairman, on that. I would change Medicaid by not requiring people to spend down any of their assets, but to lock them in, so that upon the death of the second member of the couple, this money then is available to repay the Government. I would also prevent people from transferring assets. I would allow them to keep all their assets, home and others, during their lifetimes.

Chairman STARK. I understand exactly what you are saying. I think what you are really telling me is we are going to deal with the estate and gift taxes. It is a claim against an estate. I understand what you are saying. I just am not sure that I do not shudder at the thoughts of the complexities there and ever getting the money.

The incentives for transferring in anticipation and paying other claims, and how do we get in line then? How would you like to have the funeral industry and everybody else who has a claim

against that estate coming after you ahead of us. And I am not so sure that does not get to be a real problem.

But that is something I do not think we are going to face this year.

Mr. BALL. Mr. Chairman, I have not checked into the Medicaid program lately, but my memory is that, as in SSI, an occupied home is not counted for eligibility, and that you are not forcing the sale of such homes. But you are other assets, other assets—

Chairman STARK. I know the SSI program. That was my bill as a matter of fact. But I did not know that in the Medicaid issue they've got the same treatment.

Mr. BALL. I think, though, you raise a different point, and that is, making it easy for people who want to recover equity that they have in the home without leaving the home. There has been a big discussion for years now of reverse mortgages in the private market but not much has happened.

Chairman STARK. They have not worked very well.

Mr. BALL. There seems to be a tremendous attachment on the part of older people—the 70 percent who own their home—to that home, probably because they hope to leave it to their children.

Now, it does seem reasonable that people who need the money, ought to have a way that they could get some of that equity out and use it and remain in the home. And I encourage you to continue to work at that.

In the nursing home area, Mr. Chairman, where Mr. Myers and I so basically disagree, this is basically, not the right forum today to argue it. But I do want to point out a few statistics.

I think most people are under the impression—I do not mean Mr. Myers—but many people are under the impression that those who go in to nursing homes are there for a long time, and that therefore nursing home care for most turns out to be very expensive. Actually, the figures are that about 50 percent of the people going in to nursing homes stay there less than three months, and 40 percent less than a month. The big expenses—90 percent of nursing home costs—are for the 10 percent who stay in more than a year.

And this is almost an ideal setup for traditional type insurance because you have a large group exposed, but very few with a big cost.

Chairman STARK. Let me ask this, and I would value your opinion.

My concern has been that if there are indeed half of our Medicare beneficiaries living on less than \$10,000 a year, is there an incentive—because nursing homes do provide 21 squares a week and clean sheets and some recreation facilities—on the part of these low income Americans to hide themselves away? So I could pretty soon translate that into thinking that I ought to have somebody to take care of me. That is a feeling. One can leave.

And I wonder then, on the other hand, that the providers see a market for 7½ million Americans which they can charge \$2,000 a month. Are we not just kind of pushing toward a growth there.

I do not know. You suggested in your article, Mr. Ball, it is definitional. We have to make sure it is insurance and not a savings program for comfortable living, which I think we should have also.

But I do not want to get this mixed up with, "Are we providing an adequate retirement income for a lot of our seniors." That is a social senior. That gets into the whole Social Security social welfare issue. And it is distinct from the health area.

Mr. BALL. Mr. Chairman, if one were to propose that you cover the full cost of being in a nursing home, including room and board cost, you would set up the kind of incentives that you have in mind. And if you made it open to people, regardless of their condition, it would.

But the purpose of Social Security and supplementary retirement income of private pensions and so on is not to build up people's estates, but to use the money for room and board costs as they go. If individual goes into a nursing home, I would still have the room and board charges paid for by their regular retirement income. And you would only be paying the extra costs under the kind of insurance plan I have in mind.

Now, you can arrive at that result in different ways, either with a substantial copayment as you go or—

Chairman STARK. What I am saying is, Mr. Ball, that those 7 or 8 million Americans cannot live on \$500 a month room and board. Now, what are they doing? They are freezing, they are going hungry for the last week of the month until the next check comes. They are doing a lot of things that you and I would just find obscene. We are not supporting them in a healthy mode in a way that we could be very proud of.

Mr. BALL. But, at the same time, if a person were going into a nursing home, I would not leave them with \$500 a month. I would use it to pay for room and board charges in nursing homes.

Chairman STARK. But what I am getting at is I am afraid that with this constituency out there, we are looking into, you know, costs in the order of maybe \$20, \$30, \$40 billion a year. And that is what I am afraid the system is not prepared to tackle overnight.

Mr. MYERS. Mr. Chairman, the reasons that you so eloquently gave are exactly the reasons why I say that it is not an insurable risk. But even for the person getting benefits of \$500 a month, if they have to give up the whole \$500, or most of it, they would still be better off in living in a fine nursing home.

Chairman STARK. I think it is attributable as Mr. Ball defines it. But I have always said that is our promise, how do we, one, define it; two, reassure those for whom it is a concern that it is not a welfare cheat program where anybody can get in? The only problem I see is how do we define who gets the benefit?

Mr. BALL. We cannot really go into the detail now, but I would certainly have a long period as a deductible—probably 3 months—before a person was eligible, during which time the individual would have to be very seriously disabled—really nursing home eligible, pretty much as defined under the Medicaid program in most States now.

I think this can be done. You are absolutely right. We have to demonstrate that it can be done and at a reasonable cost, and I intend to spend quite a bit of time on trying to do that, Mr. Chairman.

Chairman STARK. Your help would be appreciated.

Mr. Gregg.

Mr. GREGG. Mr. Myers, I wanted to follow up on this idea, which did not capture the imagination of the chairman but to which I am interested, that of somehow tying in the question of the family home. Perhaps we could allow the person to retain the family home, but create some lien against the family home as the Federal Government incurs the cost of maintaining that person in his long-term care situation.

Can you give us some more specifics as to how you would incorporate this idea?

Mr. MYERS. Yes. I would extend this non-spend down feature, not only to the home; I recognize that for persons living in the home, they do not need to spend it down. But in addition I would extend the nonspend down to all their assets. If people had savings accounts or owned any investments or anything like that, I would not require any spend down of that for nursing home care, but rather lock that money in so that it could not be disposed of or passed on to somebody else. The spouse could have the advantage of the income from that during his or her lifetime.

Mr. GREGG. So you would give them a life estate, basically—

Mr. MYERS. Yes.

Mr. GREGG [continuing]. With those assets.

Would there be an actual conveyance of a life estate, including assets generating income as well as usage of those assets when a person decides to go into a long-term care facility? Would there be this front-end approach to it, or would there be a rear-end approach, such as a lien? What mechanism are you using?

Mr. MYERS. I am not at all familiar with the various legal aspects of how to do this. But the result I want to achieve is to have people have control over all their assets; not until the death of the second member of the couple would any lien come due. But I would definitely have that provisional lien.

If the taxpayers are to support these persons in the nursing home, it seems to me they should come in line ahead of the survivors of the individual.

Mr. GREGG. Now, how would that be tied into the premium? Or how would you fund the nursing home care, pending the—

Mr. MYERS. This would be done through Medicaid, out of general taxes. Therefore I think that the general taxpayer should get whatever money there is in the estate of the couple after they both pass from the scene, recognizing that certain other expenses like the funeral expenses might come first. But general taxpayer they should be one of the top creditors, as it were.

Mr. GREGG. Thank you.

Mr. BALL. Mr. Chairman, I know this is not supposed to be a debate between us—and as the years have gone on, Mr. Myers and I have come closer together on our views on many things in the social security program—but I cannot really let go without comment. One point that he made earlier I think he gave the impression that patients are in control of when they leave hospitals. It seems to me that to whatever extent physicians may have at one time taken the wishes of a patient into account, within a day or so, say, that under the pressure of the DRG method of reimbursement, there is not much of that left—a little probably, but not much. I would not change the design of the plan, such as moving up the

copayment for the skilled nursing home benefit to the first few days rather than having it in the later period based on the notion that it is the patient who determines either when he enters the hospital or when he leaves. Physicians do that.

Chairman STARK. I am inclined to believe, but that is what my staff tells me.

Gentlemen, thank you very much. Your testimony is very important to this committee, and I hope you will stay in close touch with us. The work that you do is important, and your continued counsel will be important as we try and take advantage of the chance that we have to accomplish something this year.

Mr. BALL. Thank you.

Mr. MYERS. Thank you.

Chairman STARK. Thank you again.

Our next panel is comprised of Dr. Judith Feder, codirector of the Center for Health Policy Studies at Georgetown; Dr. Gail Wilensky of the Center for Health Affairs, Project HOPE; Lynn Ethredge, the health policy consultant for the Consolidated Consulting Group.

Welcome to the panel. And would you like to proceed in the order that you are listed on the witness sheet and expanding or summarizing or elaborating on your testimony in any way you desire.

Dr. Feder.

STATEMENT OF JUDITH FEDER, PH.D., CODIRECTOR, CENTER FOR HEALTH POLICY STUDIES, GEORGETOWN UNIVERSITY SCHOOL OF MEDICINE

Ms. FEDER. Thank you, Mr. Chairman.

I appreciate the opportunity to testify before you this morning. My testimony is based on research we have done using survey data on the elderly's income and health spending.

Looking only at acute medical care, that means putting aside the important but separate issue of long-term care, our research indicates that, despite Medicare, a large proportion of the elderly experience catastrophic financial burdens due to illness; that about half the burden comes from expenses that Medicare does not cover; that burdens are greatest for the lower income elderly and the very sick, and the financial burdens appear to limit access to medical care by elderly in poor health who lack private medigap insurance or Medicaid to supplement their Medicare coverage.

I would like to discuss each of these findings in turn.

First, what financial burden does illness impose on the elderly? To answer that question, it is necessary to look not just at medical expenses but at medical expenses in relation to income. Large medical bills may constitute a financial catastrophe for any individual, but for individuals with low incomes, even relatively small expenses can be catastrophic.

In 1986, almost a quarter of the elderly spent more than 15 percent of income on medical bills. For about half the elderly, catastrophic burdens resulted from expenses of less than \$1,500.

I think it is useful to consider why, given the Medicare program, so many people face such large burdens. Although Medicare fi-

nances most of the elderly's acute medical care, the program excludes certain services from coverage: prescription drugs outside the hospital, dental care, eyeglasses for example, and it requires premiums and cost-sharing for that services it does cover.

Services that Medicare excludes, and that would be excluded from most of the proposed caps, which are limited to Medicare covered services, account for about half the bills the elderly pay out of pocket.

Let me give you some examples of how Medicare's gaps create catastrophic burdens. To take a person who is suffering from heart disease, who requires a bypass operation, Medicare will pay the bulk of that person's hospital bill, about \$15,000, for a stay of 2 weeks. But the patient will still face a total bill of \$2,500 or \$3,000: \$520 for the hospital deductible, and more than \$2,000 as the patient's share of about \$10,000 in physician bills.

Big bills can arise even if a person does not use the hospital. Drug expenses, which Medicare does not cover at all outside the hospital, can be quite substantial. For example, a person with high blood pressure may spend more than \$100 a month on the multiple medications needed to prevent strokes.

Whether these out-of-pocket expenses are catastrophic depends on how much money people have, as you pointed out, Mr. Chairman. Spending \$1,200 or \$1,500 may not be catastrophic for a person with \$20,000 in income, but it could be either catastrophic or prohibitive to a person living on \$6,000 or \$7,000 a year.

Because Medicare requires equal cost-sharing of all beneficiaries, regardless of income, lower income elderly are most likely to face catastrophic burdens. And because Medicare cost-sharing rises with the use of services, catastrophic burdens are worst for the low income population who gets sick.

Neither private Medigap policies nor the public Medicaid program eliminate these financial problems for the lower income elderly. Many lower income elderly cannot afford medigap coverage, and about two-thirds of the poor elderly are not eligible for Medicaid.

While medigap and Medicaid may not prevent catastrophe, they do appear to improve access to care. As we would expect, people with either kind of supplementary protection, medigap or Medicaid, use more medical care when they are in poor health than when they are in good health. But among people who have only Medicare to finance their care, we find that people in poor health use little more care than people in good health. They simply cannot afford it.

Catastrophe then is just not financial. High medical costs and no insurance means that some people go without care.

The proposals now before you to expand Medicare can help alleviate these problems. But as you consider Medicare improvements, I call your attention to two critical issues: one, half the elderly's catastrophic costs are for services that Medicare does not cover; and, two, the poor and near poor experience catastrophe or forgo

care long before they spend \$1,000, let alone \$2,000 on medical care. Any policy that fails to take these facts into account will not address the major sources of catastrophe among the nation's elderly.

Thank you.

[The prepared statement follows:]

Judith Feder, Ph.D.
Co-Director
Center for Health Policy Studies
Georgetown University, School of Medicine

Mr. Chairman, Members of the committee: I am Judith Feder, Ph.D., Co-Director of the Center for Health Policy Studies of the Georgetown University School of Medicine. I appreciate the opportunity to testify before you today on elderly citizens' need for improved insurance protection against catastrophic medical costs. My testimony is based on research I have done with Marilyn Moon, Ph.D., and William Scanlon, Ph.D., using the National Medical Care Use and Expenditure Survey. (That survey was conducted in 1980. Responses have been adjusted to approximate experience in 1986).

Looking only at acute medical care--that is, putting aside the issue of catastrophe due to long-term care--our research indicates that despite Medicare, a large proportion of the elderly experience catastrophic financial burdens due to illness; that about half these burdens come from expenses that Medicare doesn't cover and that would not be covered by caps on Medicare-covered services; that burdens are greatest for the lower income elderly and for the very sick; and that financial burdens appear to limit access to medical care by elderly in poor health who lack private Medigap insurance or Medicaid to supplement their Medicare coverage.

Let me discuss each of these findings in turn. First, what financial burden does illness impose on the elderly? To answer this question, we look not just at medical expenses but at medical expenses in relation to individuals' incomes. Large medical expenses may constitute a financial catastrophe for any individual, but for individuals with low incomes, even relatively small expenses can be catastrophic.

In 1986, elderly citizens spent an average of 11.2 percent of income out-of-pocket on medical care. More important, almost a quarter of the elderly spent more than 15 percent of income on medical bills. For about half of these elderly, catastrophic burdens resulted from expenses of less than \$1,500.

Why, given the Medicare program, do so many people face such large burdens? Although Medicare finances most of the elderly's medical care, the program excludes certain services from coverage--like prescription drugs, dental care, and eye glasses--and it requires premiums and cost-sharing for the services it does cover. Services that Medicare excludes--and that would be excluded from most proposed caps--account for about half the bills the elderly people pay out-of-pocket.

Let me give you some examples of how Medicare's gaps create catastrophic burdens. Take a person suffering from heart disease who requires a by-pass operation. Medicare will pay the bulk of the hospital bill for this operation, which may run about \$15,000 for a stay of 2 weeks. But the patient will still face a total bill of about \$2,500 to \$3,000. Of that \$520--the Medicare hospital deductible--will go to the hospital. The remainder is the patient's share of about \$10,000 in bills from the surgeon, the anesthesiologist, and various physician consultants. Or consider a woman who needs a hip replacement. Her out-of-pocket expenses would be about \$1,500--the hospital deductible (\$520) plus about \$1,000 in physician fees.

Big bills can arise even if a person never uses the hospital. Drug expenses, which Medicare does not cover at all outside the hospital, can be quite substantial. A person with high blood pressure, for example, can spend more than \$100 per month on the multiple medications needed to prevent a stroke.

Whether these out-of-pocket expenses are catastrophic depends on how much money people have. Spending \$1,200 or \$1,500 might not be catastrophic for a person with \$20,000 in income, but it could be either catastrophic or prohibitive to a person living on \$6,000 or \$7,000 a year.

Because Medicare requires equal cost-sharing for all beneficiaries, regardless of income, lower income elderly are most likely to face catastrophic burdens. More than half the elderly have per capita incomes below \$10,000. This population has an average out of pocket expense of 14 percent of income--almost twice the share paid by elderly with income above \$10,000. And about one in nine of these lower income elderly devoted more than 25 percent of income to medical care.

Elderly people who use the hospital (and more than one fifth do every year) also have very large burdens. On average, elderly people who used the hospital spent 17 percent of income on medical care in 1986, compared to 10 percent for elderly who did not need the hospital.

Neither private Medigap policies nor the public Medicaid program eliminate these financial problems for the lower income elderly. Many lower income elderly can't afford Medigap coverage. And, for the near poor, Medicaid becomes available after, not before, catastrophe strikes. Unlike Medicare, Medicaid aims to cover all medical costs for the poor. However the income standards that determine eligibility for Medicaid fall well below the poverty line in many states. Nationally, Medicaid covers only 36 percent of the elderly poor outside institutions. Furthermore, many people who do qualify for Medicaid, do so by "spending down"--reducing their resources to Medicaid eligibility levels by spending on medical care. In other words, Medicaid does not prevent impoverishment; it finances care to people who are or become impoverished.

While Medigap and Medicaid may not prevent financial catastrophe, however, they do improve access to care. Elderly people with a Medigap policy or Medicaid get a lot more medical care than people without supplements to Medicare. As we would expect, people with either kind of supplementary protection use more medical care when they report poor health than when they report good health. But among people who have only Medicare to finance their care, people in poor health use little more care than people in good health. They simply can't afford it.

Catastrophe, then, is not just financial. High medical costs and no insurance means that some people go without care.

Proposals now before you to expand Medicare can help alleviate these problems. But as you consider Medicare expansion, keep in mind two critical issues (1) half the elderly's catastrophic costs are for services Medicare doesn't cover and (2) the poor and near poor experience catastrophe or forego care long before they spend \$1,000 let alone \$2,000, on medical care. Any policy that fails to take these facts into account will not address the major sources of catastrophe among the nation's elderly.

Chairman STARK. Thank you very much.
Dr. Wilensky.

**STATEMENT OF GAIL R. WILENSKY, PH.D., VICE PRESIDENT OF
THE CENTER FOR HEALTH AFFAIRS, PROJECT HOPE**

Ms. WILENSKY. Thank you.

Mr. Chairman, thank you for inviting me here to testify before the Subcommittee. I am vice president of Project HOPE. I am here, however, as an independent health policy analyst and not as a representative of Project HOPE.

As all of us here know, the elderly are heavy utilizers of medical care. Per capita, they spent about \$4,200 in 1984 as compared to \$1,700 by the rest of the population.

Medicare has accomplished much of its initial purpose, in insuring payment for the major portion of hospital and medical bills for the elderly. For example, in 1983, about 90 percent of the elderly had less than \$1,000 of out-of-pocket liability for Medicare covered services, and less than one-half of 1 percent had expenditures as large as \$5,000 in out-of-pocket liabilities.

Nonetheless, although the likelihood of incurring very large liabilities for Medicare services are small, the risk is there that a beneficiary will face unlimited out-of-pocket expenditures through a variety of health care needs.

As you also know, virtually all of the elderly receive Medicare coverage. About two-thirds have medigap, another 13 percent have Medicaid. The coverage under Medicare has already been discussed and is well-known to you.

The coverage under medigap is more difficult to ascertain. According to estimates that were prepared as part of the catastrophic report delivered to the President recently, no more than half of those with medigap coverage have policies which meet the requirements of the Baucus amendments. While Medicare will cover most of the Medicare covered services, about 82 percent, there still are substantial amounts, particularly of part B, that are uncovered. Only about two-thirds of the expenditures in fact under part B are covered by Medicare.

There are a variety of plans being considered to meet the deficiencies of the current Medicare structure. The administration is in the process of introducing a plan based on the Bowen report. It would have a maximum out-of-pocket liability of \$2,000 and an additional premium on all beneficiaries who choose part B, approximately 95 percent of all the elderly. The premium is currently estimated at about \$4.92 per month to have it be actuarially fair. This proposal would correct many of Medicare's problems.

Your bill, introduced along with Mr. Gradison, represents a somewhat different approach, although the basic purpose is the same, that is to cap out-of-pocket liabilities for Medicare beneficiaries. The most significant difference, it seems to me, is in terms of its financing. Your bill has the portion of Medicare financing, which is publicly funded, that is the part which was not contributed by the individual, included in the beneficiaries' taxable income as well as the part not covered in part B by the premium also included in taxable income and, therefore, subject to the income tax.

There are several major advantages to Stark-Gradison.

While many have questioned the use of a part A and part B distinction, there is a distinct advantage to maintaining the separation in catastrophic coverage as long as it continues to be part of the noncatastrophic coverage.

In terms of its most important feature, the bill clearly limits out-of-pocket liability. The approximate maximum liability is \$1,700, including one hospital deductible of approximately \$540, a 20 percent copay on the first 7 days of skilled nursing homes, and a maximum of \$1,000 on part B.

It has been estimated that about 5 million beneficiaries will be impacted by these new provisions.

The advantage of the financing mechanism, however, which, as I have indicated, is to my mind the most important difference in the bill is at least twofold.

First, the additional Medicare benefit is financed according to the beneficiary's ability to pay rather than by a flat premium. And, most importantly, it introduces the concept of ability to pay into the Medicare program. It has been estimated that about 35 percent of the elderly would be subject to taxation, and estimates are available indicating that for those in the lower bracket, the liability would be about \$265, and for those in the upper bracket of 28 percent under the new tax bill, the liability would be a little under \$500.

The introduction of the ability to pay concept may have the most far-reaching impact of all of the provisions in the bill. As I have said, it establishes not only the ability to pay as a meaningful concept in financing acute catastrophic care, it sets a precedent for including ability to pay more generally in the Medicare program. Give the long-run financing problems facing the Medicare program in the late 1990s and the early 21st century, this is an important precedent to have established.

Several problems obviously remain. You have heard them already, primarily the care which Medicare and therefore Stark-Gradison do not address. The most important are outpatient prescription drugs, and the most significant reason that the elderly have financial catastrophe, that is long-term care. A substantial amount of innovations is occurring in that area, such as home equity conversions, community—long-term retirement communities, and, most importantly, experimentation with long-term care insurance, particularly the concept of introducing it in the workplace as the Travelers plan recently has done.

These promise much hope that the private sector, can be brought in to meet some of the problems of long-term care.

I would like to close using a paraphrase of your own words; even though the bill that you have introduced does not meet all the problems that exist in the Medicare program, particularly in these two areas, I heartily agree with the concept of not letting the ideal be the enemy of the good. The bill which you have introduced makes a significant improvement over the current Medicare law, and I strongly recommend that it be given the most serious consideration.

Chairman STARK. Thank you very much.

[The prepared statement follows:]

STATEMENT OF

GAIL R. WILENSKY

Mr. Chairman, thank you for inviting me to testify before the Health Subcommittee, Committee on Ways and Means. My name is Gail Wilensky. I am the Vice President of Health Affairs at Project HOPE. I am here, however, as an independent health policy analyst and not as a representative of Project HOPE.

The purpose of my presentation is to discuss the financing of acute catastrophic health care for the elderly and to support the Stark/Gradison Medicare Part A and Part B Catastrophic Protection Act of 1987 as one example of legislation which would significantly enhance the ability of the elderly to meet their catastrophic acute care needs.

Nature of the Problem

The elderly are heavy utilizors of medical care and spend substantially more than the rest of the population. The elderly per capita spent \$4202 in 1984 as compared to \$1721 for the whole population. Partially in response to this higher need for medical care and partially in response to the lower economic status of the elderly that prevailed in the 1960's, Congress passed Medicare legislation as a means of financing health care for the elderly.

Medicare has accomplished much of its initial purpose in insuring payment for the major portion of hospital and medical bills for the elderly. In 1983, 90 percent of the elderly had less than \$1000 of out-of-pocket liabilities for Medicare-covered services, and less than one-half of 1 percent of the elderly had more than \$5000 of out-of-pocket liabilities. Nonetheless, the threat of acute catastrophic expense remains for millions of the elderly. Although the likelihood of incurring substantial out-of-pocket expenses for Medicare liabilities is small, Medicare beneficiaries face the risk of unlimited out-of-pocket expenditures for a variety of health care needs.

Insurance Coverage for the Elderly

Virtually all of the elderly receive Medicare coverage. Part A of Medicare covers hospital and skilled nursing facilities and is financed by the Health Insurance Trust Fund; Part B covers physician services and certain other services, is voluntary and is financed by a combination of premium and general revenue funds. Approximately 95 percent of all beneficiaries choose Part B in addition to receiving Part A.

About two-thirds of the elderly also purchase supplemental insurance policies, called "Medigap" policies. These policies vary substantially in terms of the coverage they provide as well as the prices that are charged. About 13 percent of the elderly population is covered by Medicaid. This leaves about 20 percent of the elderly population which only has Medicare. While the Medicare-only population is more likely to be lower income, in poorer health status and older than the Medicare population as a whole, there are substantial numbers of the Medicare-only population who are neither poor, sick nor the old-old. For example, while 25 percent of the low-income elderly are Medicare-only, almost 17 percent of the middle income elderly are Medicare-only and 15 percent of the high-income elderly are also Medicare-only.

Depth of Coverage

Medicare Part A provides coverage for 60 days of inpatient hospital care without charge within a single "spell of illness" following the payment of the first day as a deductible. It covers days 61 through 90 with a co-payment equal to one-quarter of the daily charge. There is also a 60-day "lifetime reserve" which has a co-payment equal to one-half the daily rate. Part A also provides for 100 days of skilled nursing home care following a hospital stay with a co-pay for days 21 through 100.

Part B of Medicare has an annual deductible of \$75 and covers 80 percent of the costs for physician services up to a maximum allowable charge per visit. It provides similar coverage for inpatient prescription drugs and outpatient services. It provides no coverage for outpatient prescription drugs or routine physician services.

The coverage under Medigap is difficult to ascertain. The last accurate population-based survey which contained detailed information on the insurance coverage of the elderly was in 1977. Since then, there have been a great many changes in the types of coverage offered the elderly, particularly as a result of the Baucus Amendments in 1980. This law established minimum benefits for policies called "Medicare Supplements," i.e. coverage of Part A co-insurance days, 90 percent of hospital expenses for a year after Part A is exhausted and a minimum coverage of \$5000 of Part B co-insurance expenses. Most policies provide coverage for the front-end deductibles and at least some co-insurance. It is unclear how many provide complete acute care catastrophic coverage. It has been estimated that no more than half of those with Medigap coverage have policies which meet the requirements of the Baucus Amendment and thus provide good, if not complete, catastrophic care.

Medicare beneficiaries who also have Medicaid generally have good acute care coverage, although some states have introduced limits on the amount of care which Medicaid can finance.

The structure of Medicare allows the beneficiary to incur substantial liabilities. The actual distribution of liabilities for Medicare-covered services, net of Medicare payments, is shown in Table 1. As already mentioned, 90 percent have out-of-pocket liabilities of under \$1000. Table 2 shows the net liabilities in terms of Part A and Part B services. Medicare covers most, 82 percent, of the total liabilities incurred for covered services. As can be seen, Medicare pays for almost 92 percent of Part A liability but only two-thirds of liabilities incurred under Part B. Thus most of the residual liability occurs for Part B. The total residual liabilities not covered by Medicare exceeded 10 billion dollars in 1983, and this, of course, only refers to Medicare-covered expenditures.

Although the information we have on the supplemental insurance policies is not very complete, the data available on the out-of-pocket expenses for those with and without insurance coverage indicate very different experiences for these two groups. According to the recent report on catastrophic illness released by the Department of Health and Human Services, the out-of-pocket expenses for those with insurance coverage was less than half of those without insurance coverage. Specifically,

- o beneficiaries with a hospital admission of less than 61 days and no private coverage had out-of-pocket expenses of \$878, while those with insurance had out-of-pocket expenses of \$474;
- o beneficiaries with a hospital admission of more than 61 days and no private coverage had out-of-pocket expenses of \$4326, while those with insurance had out-of-pocket expenses of \$1698

Proposals to Provide Acute Catastrophic Coverage

There is a wide variety of strategies which could be developed to meet the acute care needs of the elderly. Several proposals have already been introduced including those by Senator Kennedy and Congressman Slaughter.

The Administration is supporting a catastrophic coverage plan based on the recommendations of the Bowen Report. Under the Administration's plan, beneficiaries would face a maximum out-of-pocket liability of \$2000. The \$2000 annual limit would reflect Part A and Part B liabilities combined. It would be financed by an additional premium on all beneficiaries who choose Part B coverage. HCFA actuaries estimate that the additional premium would cost \$4.92 per month in the current year. The Congressional Budget Office estimates an actuarially sound premium would cost \$6.40 per month in 1988. The \$2000 cap would be indexed each year to account for health care inflation. This provision along with the self-financing premium was established to insure budget neutrality. This proposal would clearly correct some of the problems associated with the existing Medicare structure.

The Stark/Gradison Bill represents a somewhat different approach although the principal purpose is the same: to limit the out-of-pocket liabilities for Medicare beneficiaries. Under Stark/Gradison, the Part A and Part B divisions of Medicare are maintained. Under Part A, beneficiaries are responsible for one hospital deductible but no additional hospital expenses. They are also responsible for 20 percent of the national average allowable daily cost on skilled nursing homes for the first 7 days and would have coverage for a maximum of 150 days per year. The cap on Part B expenditures is set at \$1000.

The most significant difference between Stark/Gradison and the Administration bill is in terms of its financing. Under Stark/Gradison, the portion of Medicare financing which is publicly funded is included in the beneficiary's taxable income and is subject to income tax. Specifically, 50 percent of the actuarial value of Part A (corresponding to the part contributed by the employer in the payroll financing) is included in the beneficiary's taxable income. Similarly, the actuarial value of Part B not funded by the premium is also included in the beneficiary's taxable income.

Strengths of the Stark/Gradison Bill

There are three major advantages to the Stark/Gradison Bill. It maintains the separation between Part A and Part B of Medicare; it caps the out-of-pocket liability for Medicare beneficiaries; and it introduces the concept of ability to pay into the financing of the Medicare program.

While many have questioned the use of a Part A and a Part B in Medicare, there is an advantage to maintaining the separation in catastrophic coverage as long as it continues to be part of the non-catastrophic coverage. Maintaining the distinction will facilitate the administration of the catastrophic component considerably.

The obviously significant feature of the Stark/Gradison Bill is that it limits the out-of-pocket liability which Medicare beneficiaries currently face. The maximum out-of-pocket payment by component is shown in Table 3. As is indicated, the maximums for 1988 are one hospital deductible or \$541, the 20 percent co-payment on skilled nursing facilities for 7 days or \$168, and a Part B liability of \$1000. The maximum total out-of-pocket liability is thus \$1709. This not only represents a substantial improvement over the current situation, it also represents a lower liability than the \$2000 associated with the Administration's bill.

Almost 5 million beneficiaries will be impacted by the out-of-pocket limits included under the Stark/Gradison proposal. This includes:

- o 2,000,000 who would have paid more than one hospital deductible

- o 215,000 who would pay a Part A hospital co-payment
- o 12,000 who would exhaust hospital coverage after 150 days
- o 170,000 who would pay more than \$150 of SNF co-insurance
- o 2,400,000 who would pay in excess of \$1000 for a Part B deductible and co-payments

The most significant advantage of the Stark/Gradison proposal is the financing mechanism being proposed. As previously indicated, 50 percent of the Medicare Part A per enrollee benefits and per enrollee benefits for Part B in excess of the premium would be added to the beneficiary's taxable income. Estimated revenue, according to the Joint Tax Committee, from this provision is:

FY 1988 - \$1.4 billion
 FY 1989 - \$4.7 billion
 FY 1990 - \$5.2 billion

The advantages of this financing mechanism are two-fold: first, the additional Medicare benefit is financed according to the beneficiary's ability to pay rather than by a flat premium across all beneficiaries; most importantly, it introduces the concept of "ability to pay" into the Medicare program. One set of estimates indicates that 34 percent of the elderly would be subject to taxation under Stark/Gradison as opposed to 95 percent under the Administration plan. For those in the 15 percent bracket in 1988, the additional tax is estimated to be \$265; for those in the 28 percent bracket the tax would be about \$495. It should be noted that because the maximum out-of-pocket liability is lower, the total cost of this program is greater than the total cost of the Administration program, \$2.18 billion as opposed to \$1.43 billion in FY 1988.

The introduction of the ability-to-pay concept may have the most far-reaching impact of all of the provisions in the Bill. It not only establishes ability to pay as a meaningful concept in financing acute catastrophic care, it sets the precedent for including ability to pay more generally in the Medicare program. Given the long-run financing problems facing the Medicare program in the late 1990's and early 21st century, this is an important precedent to have established.

Conclusion

The Stark/Gradison Bill limits Medicare out-of-pocket liabilities to approximately \$1700 for Medicare-covered services. It does so retaining the Part A and Part B distinction and would affect some 5 million beneficiaries. Its most significant feature, however, is the use of an ability to pay financing mechanism, achieved by including a portion of the actuarial value of Medicare in a beneficiary's taxable income. Both as a means of financing acute care catastrophic and as a precedent for Medicare in general, this is a critical element.

There are several problems associated with Medicare that Stark/Gradison does not address. Acute care items excluded under Medicare remain excluded. Most prominent among these is outpatient prescription drugs. Even more significantly, it does not impact long-term care expenditures, the primary reason for financial catastrophe of the elderly. However, to paraphrase Mr. Stark, "Let us not permit the ideal to be the enemy of the good." The Stark/Gradison proposal makes a significant improvement over current Medicare law. It should be given the most serious consideration.

Table 1

DISTRIBUTION OF NET BENEFICIARY LIABILITIES
UNDER MEDICARE, 1983

Average Net Per Capita Liability	Distribution of Beneficiaries		Distribution of Net Liabilities	
	Total (Millions)	Percent	Total (\$ Billion)	Percent
\$0	5.3	19.6	\$0.0	0.0
\$1-999	19.0	70.1	4.7	45.8
\$1,000-1,999	2.0	7.2	2.7	26.0
\$2,000-4,999	0.7	2.7	2.1	20.2
\$5,000 & over	0.1	0.4	0.8	8.0
TOTAL	27.1	100.0%	\$10.3	100.0%

SOURCE: HCFA Office of the Actuary.

Note: Beneficiary liabilities are net of Medicare payments only. They are further reduced to some extent by payments under Medigap policies. Cited in Catastrophic Illness Expenses, Department of Health and Human Services Report to the President, November 1986, p. 27

Table 2

PAYMENTS AND NET BENEFICIARY LIABILITIES
UNDER MEDICARE, 1983

	<u>Total Expenditures</u>		<u>Medicare Payments</u>		<u>Net Beneficiary Liabilities</u>	
	(\$ billion)		(\$ billion)	% of Total	(\$ billion)	% of Total
Part A	\$35.3		\$32.4	91.8%	\$ 2.9	8.2%
Part B	\$22.1		\$14.7	66.5%	\$ 7.4	33.5%
TOTAL	\$57.4		\$47.1	82.1%	\$10.3	17.9%

SOURCE: HCFA Office of Research.

NOTE: This table reports Medicare payments and net beneficiary liabilities consistent with Table 1. Beneficiary liabilities are net of Medicare payments only. They are further reduced to some extent by payments under Medigap policies.

Cited in Catastrophic Illness Expenses, Department of Health and Human Services Report to the President, November 1986, p. 33

Table 3

Maximum Out-of-Pocket Medicare Liabilities in 1988
Under the Stark/Gradison Proposal

<u>Category of Liability</u>	<u>Maximum Liability</u>
Hospital deductible (limit of one per year)	\$ 541
SNF co-payment (first 7 days with 150 day limit)	168
Part B	<u>1,000</u>
Total Maximum Liability	\$1,709

Chairman STARK. The next witness is Mr. Etheredge, to whom I apologize for my previous gender error. You can be happy that your parents didn't decide to make it Fortney. [Laughter.]

This is even, I can assure you, a worse cross to bear.

Proceed, Mr. Etheredge, in any manner that you are comfortable.

STATEMENT OF LYNN M. ETHEREDGE, HEALTH POLICY CONSULTANT, CONSOLIDATED CONSULTING GROUP

Mr. ETHEREDGE. Thank you, Mr. Chairman.

I appreciate the invitation to testify this morning on financing of Medicare catastrophic benefits. It seems to me that there are really two basic issues that have to be faced. One is the distribution between the under-65 and the over-65 population. The other is how to distribute the burden most fairly within the over-65 population.

The intergenerational issues are dealt with partly in my testimony. Since they are not really the central issue being debated today, I would just summarize two points. One is that Medicare is already a very heavily subsidized program for the elderly. Ninety-three percent of the total revenues coming into Medicare are from taxes, payroll taxes, and general revenue taxes, paid by the working population, and only 7 percent of the revenues are now coming from the over-65 population. So it is a very heavily subsidized program for the elderly already.

The second point is that, in the premium or cost range which we are discussing this morning of \$5 to \$15 a month, we already have quite good evidence that many of the elderly can afford to pay those premiums themselves because, in fact, they are paying that and considerably more in private medigap coverage.

So let me turn to what I think is the main issue between the two proposals that the committee is considering—using premium financing and income tax financing—and briefly contrast what I understand to be the pros and cons of those two approaches.

An across-the-board premium, like the SMI premium, has some good arguments for it for many of the elderly. We know that most of the elderly, over two-thirds, are already buying private medigap, at premium prices, and if they were asked to simply finance the same benefits by paying Medicare premiums, they would, in fact, save a considerable amount of money because of the lower administrative costs.

In fact, an elderly person paying a \$600 premium might even save \$100 a year because of the lower administrative costs.

I think the disadvantage, though, of across-the-board premium financing is not the equity for the typical or upper income elderly person, but the problems of low-income elderly. Dr. Feder and the chairman have already mentioned this several times, as have other witnesses: Our problem is that Medicaid, which is not within the jurisdiction of this committee is just not adequate to take care of the low-income elderly.

Only 36 percent of the elderly even living in poverty now receive Medicaid benefits, and that means that the out-of-pocket expenses faced by this group already are very high. These expenses could easily be 20 percent or more at income at the lowest income levels.

So I think that the disadvantage of the premium across-the-board approach is it would add to what are already extremely heavy burdens on the lowest income elderly.

That leads us to the second strategy, which is to look at whether resource-related or income-related financing of Medicare should be sought from the elderly. I think there are some very strong arguments for doing so. One is the subsidy value of Medicare, which is not included in adjusted gross income. The committee has already set a precedent in the Social Security Amendments of 1983 to tax part of the subsidy value of Social Security for higher income elderly and has also in the Tax Reform Act generally followed the principle of broadening the base to include more sources of income in order to keep down rates.

So there are arguments for income tax financing, but there are also some liabilities, which I am sure this committee is aware of and others will point out as well. The problem is that because Social Security is not counted as taxable income for most of the elderly, more than half have no tax liability. And that means that the full cost of this Medicare catastrophic plan, if put entirely on the tax system, is going to fall on about 45 percent of the elderly.

That could be an unpleasantly large burden. If we are looking at about a \$1,500 increase in adjusted gross income at the 28 to 33 percent tax rates the increased taxes could be \$400 or \$500 per person or \$800 to \$1,000 a couple if this were done all at one time, the first year. That could be unpleasantly large for some people.

In sum, I think the committee really has two choices, both of which have some unsatisfactory characteristics. One is I think damaging to the poor. The other is arguably somewhat unfair to the highest income elderly. If those two choices alone don't suffice, of course, there are many other ways to raise revenues: alcohol and tobacco taxes, extending the HI tax to State and local employees, raising the HI rate, or even an estate State tax, as some have ventured to suggest this morning.

Thank you, Mr. Chairman.

[The prepared statement follows:]

TESTIMONY OF MR. LYNN ETHEREDGE
BEFORE THE HOUSE WAYS AND MEANS COMMITTEE

MARCH 4, 1987

Mr. Chairman and Members of the Committee:

I appreciate the invitation to testify before you this morning on the subject of financing Medicare catastrophic insurance benefits.

My background includes serving as a Medicare program analyst with the Office of Management and Budget from 1971-1976 and as director of its professional health staff from 1978-1982. Since leaving government, my research and other activities have continued to deal mostly with issues of health and long term care for the nation's elderly population.

Current Financing of Health Care for the Elderly

Government health insurance -- particularly the Medicare program -- has a lead role in financing health and long term care services of the elderly population. In 1984, the nation spent over \$120 billion on health care for the elderly (\$4200 per capita). Federal and state governments paid over two-thirds of this amount -- and Medicare alone paid nearly one-half. Private insurance financed only 7% of spending, mostly (89%) in Medigap-type products which wrap around Medicare's hospital and physician coverage.

Health Care Financing for the Elderly
1984 (\$ Billions)

	<u>Total</u>	<u>Hospital</u>	<u>Physician</u>	<u>Nursing Home</u>	<u>Other</u>
Total	<u>\$120</u>	<u>\$54</u>	<u>\$25</u>	<u>\$25</u>	<u>\$16</u>
Public	67%	89%	60%	48%	35%
Medicare	49	75	58	2	20
Medicaid	13	5	2	42	12
Other govt.	5	9	-	4	3
Private	33%	11%	40%	52%	65%
Insurance	7	8	14	1	5
Out-of-pocket	25	3	26	51	60

Source: D. Waldo, H. Lazenby "Demographic Characteristics and Health Care Use and Expenditures by the Aged in the United States: 1977-1984, Health Care Financing Review, Fall 1984

Despite the substantial government assistance to the elderly, it is important to note that there are still major gaps in their insurance protection. More than 25% of their total expenses -- \$30 billion (\$1000 per capita) -- were paid out-of-pocket by the elderly in 1984. I recognize that private insurance companies are concerned about potential loss of a portion of their current Medigap revenues if the Medicare program is expanded to include

catastrophic acute care coverage. Nevertheless, these out-of-pocket expenses show there are potential markets of several tens of billions of dollars per year, particularly in long term care, into which private insurance can expand and thereby provide better protection for our senior citizens.

The Medicare program, which is this Committee's major concern, now draws on three different revenue sources. The hospital insurance (HI) program is financed mostly from payroll taxes (1.45% each from employers and employees on the first \$43,800 of wages) which individuals contribute during their working lives in order to receive benefits in retirement. In contrast, the supplementary medical insurance program (SMI) for the elderly is financed by a combination of general revenues (75%) and enrollee premiums (\$17.90/ month) (25%). The vast majority of Medicare's revenues (93%) now come from general population taxes, while only 7% come from the enrollee's premiums:

Medicare Trust Fund Revenues
(CY 1986, \$ Billions)

<u>Revenue source</u>	<u>Amount</u>	<u>%</u>
HI payroll taxes	\$54.2	65%
General revenues	23.9	28%
Enrollee premiums	<u>5.8</u>	<u>7%</u>
Total	\$83.9	

Source: HI and SMI Trustees Reports, 1986

Thus Medicare's current financing provides a substantial subsidy, mostly paid by the under 65 population, to assist the over 65 population in paying for their medical bills. These benefits exceed the amounts which individuals "prepay" by contributions during their working careers. For HI, a recent estimate shows that individuals who retired in 1983 had made average contributions (including accrued interest) of \$2,690 in HI taxes, but could expect to receive \$28,000 (male) to \$34,000 (female) in benefits -- 10-12.5 times their contribution.¹ For the SMI program, elderly enrollees receive benefits which are four times their premium contributions.

Should expanded Medicare benefits for the elderly be financed by general revenues or by the over 65 population?

The more than two decades which have passed since Medicare was enacted have seen substantial improvements in the economic status of the elderly population. In 1966, for example, 28.5% of all persons 65 years old and over had incomes below the poverty standard, a rate which was nearly double the 14.7% rate for all persons. By 1984, the proportion of elderly persons in poverty had actually fallen to 12.4%, while the overall poverty rate remained little changed at 14.4%.²

A general economic comparison of the elderly and the non-elderly today can also be made by income and net worth data. In 1983, households headed by persons 65 and over had mean per capita incomes of \$8,113 after taxes, about 10% greater than the \$7,383 average for all households.³ In 1984, the median net worth of households headed by persons 65 years of age and over was \$60,300, compared to \$32,700 for all households.⁴

There are, of course, numerous complexities in comparing the economic welfare of the over 65 and under 65 populations simply on the basis of averages and poverty status. There are many lower (and higher) income persons in both the over 65 and under 65 populations. Many elderly persons no longer have mortgage payments, receive substantial non-cash benefits (like Medicare)⁵, and have more leisure than persons still in the work force; on the other hand, the elderly also have higher out-of-pocket medical expenses than the non-elderly and threats of catastrophic health and long term care expenses. Nevertheless, it is clear that Medicare's financing from the under 65 population is now going, in part, to subsidize medical care of persons over age 65 who could afford some of this medical care from their own resources.

The Congress has already started to reshape government assistance for the elderly in light of their improved economic welfare compared to the working population. Starting with the Social Security Amendments in 1983, Congress provided that half of social security benefits should be included in taxable income for persons over 65 with adjusted gross incomes of over \$25,000 (single) or \$32,000 (couple). The same reasoning suggests we now should look to the elderly population, or at least its more affluent members, to see whether they can finance improved Medicare catastrophic insurance without additional contributions from the under 65 population.

How should Medicare financing be shared among the 65+ population?

There are at least two ways in which the added costs of Medicare catastrophic protection might be financed by the elderly. The first is through across-the-board premiums, which is the way the SMI program has been financed. The second is through resource-related or means-related financing, such as the personal income tax.

--Premium-based financing The major problem with using across-the-board premium financing is the very poor basic health insurance coverage now available for many of the low income elderly population. This results, in large measure, from uneven (and low) Medicaid eligibility levels. Only about 36% of the elderly living in poverty are now eligible for the Medicaid program. This has been true, in large part, because of the levels which have been established for SSI program eligibility and the links between such cash assistance and Medicaid program coverage. In 1986, Federal SSI benefits were estimated to be 76% of the poverty level for individuals and 90% of poverty level income for couples and countable assets, excluding a home, were limited to \$1700 (individuals) to \$2550 (married couples).⁶ In fourteen states ("209 B" states), Medicaid eligibility levels were even more restrictive than these standards.

As a result of these gaps, even after Medicare and Medicaid benefits, the lowest income elderly still faced very heavy health care expenses in relation to their income. As of 1984, estimates showed that even non-institutionalized elderly persons with per capita incomes below \$5,000, after Medicare and Medicaid coverage, still had out-of-pocket health care expenses of 22% of their incomes.⁷ These amounts were averages, so many persons had greater financial burdens, as did individuals who were in hospitals or nursing homes and not included in the survey data.

Medicaid's basic eligibility rules have been somewhat modified since these estimates were made, in the Sixth Omnibus Reconciliation Act (1986) which granted states the option of extending Medicaid eligibility to elderly persons whose incomes do not exceed the poverty level. But these improvements were not mandatory and it is too early to tell how far this option will go in lowering the out-of-pocket burdens of even the elderly population living in poverty.

Two lines of reasoning suggest, however, that the potential adverse effects of premium financing of Medicare catastrophic insurance would not be a drawback for many of the elderly, i.e. that a \$15/month premium would not mean a net reduction of their economic welfare. These considerations are that: (1) premium-financed insurance is primarily a way to budget expenses which would be incurred anyway, so that premium-financing (aside from administrative costs and some induced utilization) does not increase the elderly's total liability; and, (2) because private Medigap coverage has high administrative expenses, many individuals will save money from paying government premiums rather than for their current Medigap policies.

These arguments are generally valid for the entire elderly population, but less so for the low income elderly. Since the benefits in question are for catastrophic expenses, which few people incur (and for which some of the low income elderly may receive forgiveness from providers), across-the-board premiums would probably mean higher out-of-pocket expenses for many of the low income elderly. Moreover, this low income group has little Medigap insurance, so they would not realize savings from dropping such coverage.

--Tax-based financing While Medicare has always had uniform, non-means-tested benefits, its revenues have always come mostly from resource-related or means-related sources, e.g. 93% of Medicare's current revenues now come from payroll taxes and general revenues. While the limitation on SMI premium changes was in effect, Medicare became increasingly a tax-financed rather than a premium-financed program.

The individual income tax system seems the best candidate for increasing means-related financing from the elderly. It is the most broad-based and equitable revenue source for general government financing. In contrast, the administrative complexity and costs of establishing a separate means-related financing system for 28 million elderly persons, solely to fine-tune financing of a limited catastrophic insurance benefit, e.g. \$5 to \$15 per month, seem unwarranted.

Higher income taxes for the elderly population are not, however, without several drawbacks. These drawbacks do not, in

my view, outweigh the advantages of using this mechanism, but the Committee should be aware of them.

The most important critique which can be made of financing Medicare catastrophic benefits by the income tax is that the full financial burdens would fall on a minority of the elderly. Since most social security benefits are still not counted as taxable income (for about 90% of the elderly), plus other income tax provisions, a majority of the elderly have no individual income tax liability.⁸ Reliance only on income tax financing from the elderly could thus be seen as inequitable in two respects. One critique is that the burdens of financing catastrophic health insurance for our lowest income elderly ought to be a broadly shared responsibility in our society, paid for through general tax revenues, not a burden placed solely on elderly persons with high incomes. A second critique is that higher income elderly persons would be paying taxes to finance benefits for some persons who could pay for their own Medicare catastrophic insurance benefits and would be better off, even after paying such an amount, because of their Medigap premium savings.

I know of no good way out of this dilemma. It would be ideal for the Medicaid program to be extended to all persons in poverty, or even beyond, so that some use could be made of premium-financing. But such actions are not the subject of this morning's hearings. Given the choice between premiums and resource-related financing, higher premiums seem particularly undesirable to the extent they would impose new burdens on lower income elderly persons. As well, the income tax approach will automatically become more equitable among the elderly over time since the Congress has not indexed the \$25,000/\$32,000 limits, and an increasing portion of social security benefits will thus gradually come within the individual income tax system.

If individual income taxes on the age 65+ population are used to finance a major part of Medicare's benefit improvements, this could be done either by increasing the adjusted gross income of taxpayers or by higher tax rates. In this regard, it seems to me that the strongest tax equity arguments are for increasing the taxable base to include one-half the actuarial value of the HI program and three-quarters of the SMI program costs in the taxable income of the elderly. This would follow the precedent of including one-half of social security benefits in adjusted gross income for elderly persons over the \$25,000/\$32,000 thresholds. It would also reflect this Committee's tax reform philosophy last year of broadening the income included in the tax base to permit lower rates. In 1987, these amounts would come to roughly \$900 per person for HI benefits and about \$650 per person for SMI benefits. These amounts could be included in adjusted gross incomes either for taxpayers over the \$25,000/\$32,000 threshold levels, or more broadly. The following table, from a recent CBO publication, shows the potential revenues:

Revenues
(FY \$ Billions)

	<u>1988</u> ⁹	<u>1989</u>	<u>1988-1992</u>
With social security income threshold	\$0.7	\$2.5	\$14.0
Without social security income threshold	\$1.4	\$5.0	\$25.6

The economic impact of this tax liability could be substantial. At the 28% and 33% marginal rates, for example, elderly individuals would face new tax liabilities of about \$400-\$500 per capita, \$800-\$1,000 per couple. This would be an unpleasantly large one-year tax increase and would be substantially more than the economic value these taxpayers would receive from a catastrophic insurance plan with benefits of about \$15/month (\$180 per person annually).

The second option for an individual income tax increase would impose an income tax surcharge for elderly persons. This would shift the financing burden even more toward the higher income individuals, and, at higher income levels, individuals' tax liabilities could exceed the value of Medicare benefits. This could be limited by setting a cap on such assessments to assure that no one paid more than benefit costs. Nevertheless, tax rate increases would be less equitable than expanding the income base because increasing the base would spread the burdens more broadly across the elderly population.

Other options

If financing Medicare catastrophic insurance solely through including part of Medicare's benefits in the adjusted gross income of the elderly would be too much of a one-time tax increase to be used alone, there are some other revenue sources which this Committee might consider. These options include:

--increasing the tobacco and alcohol excise taxes. This step was recommended by the 1982 Social Security Advisory Council (Medicare) to reflect the added Medicare expenses which result from use of these products. These rates also have not kept pace with inflation over the past several decades and have fallen as a proportion of product costs. A doubling of these rates would raise about \$8.7 billion in revenues.

--expanding HI payroll tax coverage to include state and local employees hired ~~after~~ ^{before} March 1986. This was recently suggested by the Reagan administration. It would be justified on the basis that most of these employees will eventually receive Medicare, as well as for consistency with recent coverage of other state and local employees. Estimated revenues are \$1.6 billion in 1987.

--a slight (.05%) rise in the HI payroll tax, e.g. from 1.45% to 1.50%. This could provide a general population contribution for the low income elderly. Estimated revenues are about \$2 billion in 1987.

--some modification of estate taxes would also be an appropriate way to finance catastrophic insurance protection, because these benefits insure estates against heavy expenses.

There are very substantial revenue possibilities from this source, with relatively modest rates, because of the exclusion of most estates from current taxes and the growing net worth of the elderly population. For the future, this could be the major revenue source which this Committee will be able to use to extend Medicare catastrophic coverage ultimately to include long term care expenses.

While I have no specific recommendations to make about these revenue sources for the Committee today, most or all of them will probably need to be tapped to finance Medicare's current benefits and the future expansions needed to meet the health and long term care needs of our elderly population.

Summary

To summarize, a public policy which asks those among the elderly who can pay for improved catastrophic insurance to do so seems the best course in light of the tax burdens on the under 65 population to finance current Medicare benefits. If the Medicaid program were more generous, there might be a good case for using across-the-board premiums to finance improved Medicare protection. But that is not a realistic option today. So a means-related approach now seems the best way to finance most benefit expansions. There are limitations to the individual income tax system for implementing such a policy but, despite its defects, it is the best available mechanism. The inclusion of subsidy values of HI and SMI benefits in the taxable income of elderly persons would improve the equity of the tax system and would be consistent with the policy directions already established for taxation of social security benefits. As well, there are several other revenue sources which this Committee could also draw on to finance benefit improvements.

¹Statement of Carolyne Davis, House Select Committee on Aging, July 30, 1985.

²Bureau of the Census, Current Population Reports, Series P-60.

³Bureau of the Census "Estimating After-Tax Money Income Distributions Using Data from the March Current Population Survey", P-23, No. 143

⁴Bureau of the Census Household Wealth and Asset Ownership: 1984, Data From the Survey of Income and Program Participation, Series P-70, No. 7.

⁵Bureau of the Census, Estimates of Poverty Including the Value of Noncash Benefits: 1983 Technical Paper 52. Depending on the valuation technique, the proportion of elderly persons in poverty drops from 14.1% to 3.3%-9.1%, compared to a drop for all persons from 15.2% to 10.2%-12.9%.

⁶Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means 1986 Edition, WMCP:99-14 pg 476

⁷Estimates by Marilyn Moon based on NMCS data.

⁸ibid pg. 97-99. As of 1982, 57% of the elderly had no individual income tax liability compared to 13% of the non-elderly adult population.

⁹ First year revenues are lower than other years because the fiscal year ends Sept. 30 before most of the tax liabilities incurred in the calendar year have been collected.

Chairman STARK. Thank you. You must all admit that even a \$1,500 or \$1,700 maximum, which we have suggested, is onerous to people with \$5,000 or \$6,000 of income or less. We could take two routes to correct that. We could either make the benefit more progressive, which is complex, or, as you hinted, try and expand or improve the Medicaid program.

So my question to you is should we fuss with income-relating the cap or the coinsurance, or would you advise us to get into the business of trying to make Medicaid more generous or less complex? It seems to me there is a lot of questions. One is an entitlement.

I just don't know which way you would prefer and why?

Ms. FEDER. I would like to start by saying I would like you to do one or the other for certain.

Chairman STARK. I would, too.

Ms. FEDER. I think also, just an expansion, if you do take an income-related approach in the Medicare program, I think that our data would suggest you would want to expand the benefit coverage, include drugs, for example, in order to really achieve the goals that you have in mind.

Chairman STARK. Before we started working on the \$1,500?

Ms. FEDER. No. Our data show that even if you go to a cap that is set at 10 percent of income, if you don't include some of the now noncovered services, you will still leave a lot of low-income people with a lot of trouble.

Chairman STARK. Okay.

Ms. FEDER. It seems to me that the choices are political ones, rather than administrative, and that the concern in income-relating Medicare benefits is that one might undermine the vast political support we have for that program. And I think that there is some risk to that, but one has to weigh those risks against the benefits.

If one finds those risks excessive, I think it becomes critical to accompany any dollar cap like those you have proposed with a Medicaid reform program that does focus on the poor and near-poor population.

Ms. WILENSKY. As I mentioned in my testimony, one of the components of your bill that is most attractive to me is the concept of introducing ability to pay. I think that, if not now, some time in the not so distant future income relating Medicare is an issue that is going to have to be faced. When one looks at the demographic changes that are projected to begin in the late 1990's and hit in much greater force by 2010 and 2020, it seems likely that there will be major resistance to maintaining the existing set of benefits in Social Security and Medicare, and that there will be much more serious consideration given to having programs such as Medicare be an income-related catastrophic program, which for the very low income would start at low levels, but for the middle and higher income start at higher levels.

I believe the big question is when politicians will be willing to start discussing this. There is likely to be enormous resistance. I agree with Judy Feder's comment that there will be a legitimate concern that if we make the program income related we may lose the popular support of Medicare, although I think this need not be the case as an income-related catastrophic program.

We are not talking about limiting the program say only to those that are 70 percent of the poverty line; we are talking about making it income-related. I think that sometimes the risk of losing popular support has been unduly exaggerated. It will be there for everyone even under income-relating. It is only a question at what point it begins.

While I believe very strongly that eventually we will need to do this, I doubt strongly that there is the political will to do it now. I am gratified to hear you even say publicly that you are willing to consider it. I would hate to see the benefits of this kind of a package put aside for what I am afraid might now be a losing battle.

Let me therefore, suggest that going the Medicaid route might be more expeditious. I would hope that you might consider or the other committee that has jurisdiction might consider the concept of a Medicaid buy-in program. Alternatively the committee can consider using a national floor for the SSI portion of Medicaid, and this assures that States now setting low levels set higher levels.

The Medicaid buy-in program makes the all-or-nothing concept of Medicaid less onerous and may also allow States to offer individuals who are near or above the poverty line the opportunity to pay a portion of the actuarial value of Medicaid as a premium with the portion relating to income. This may be a preferable way to increase the Medicaid rather than by increasing current eligibility levels. With all the concern that Medicaid is already becoming too much a program for the elderly. The buy in route may be more acceptable, especially if the nonelderly near the poverty level were also allowed to buy in.

For most of the population, the \$1,700 maximum total liability should not be a major problem, and it would not be appropriate to reduce the liability for everybody because of your concern for the poor. There is, however, good reason for worrying about the \$1,700 for the lowest income people not covered by Medicaid and it ought either to force you to consider income-relating the whole program, if you are ready to take this fight on, or to do some tinkering with Medicaid.

Chairman STARK. Thank you.

Mr. Etheredge?

Mr. ETHEREDGE. Thank you. I would certainly agree that Medicaid needs to be improved, at least up to the poverty level or beyond, and I think that ought to be a first step. Unfortunately, the committee has to deal with Medicare in the absence of some of those improvements. So I think that the real question here is whether to means relate the benefit side, or means relate the financing side.

I think it is better both administratively and politically to do this income adjusting on the financing side. We know that the elderly, given a chance, will buy insurance against virtually all medical care. They want comprehensive coverage. So I would think comprehensive coverage would be very popular; in fact, with even lower out-of-pocket limits for everyone than the committee has.

Adjustments so that higher income people pay more and lower income people pay less can be done by working on the financing side. I wish that the income tax were a little more equitably distributed than it is now for the elderly. But over time it will become

so because the committee has not indexed the \$25,000 and \$32,000 limits. So over time more of the total resources of the elderly population will come within the tax system.

I think that it is best to try to preserve an across-the-board benefit for all of the elderly, and one can achieve virtually the same result as means-testing benefits by a combination of Medicaid and the tax system.

Chairman STARK. Thank you.

Mr. Pickle?

Mr. PICKLE. Mr. Chairman, I will reserve my time. Thank you.

Chairman STARK. Mr. Donnelly?

Mr. DONNELLY. Thank you, Mr. Chairman. I just have a followup question on the ability to pay concept or means testing, as I call it.

Do you all agree that we just simply cannot afford to create a new entitlement program without putting some means test or ability to pay mechanism in there, whether it would be on the financing side or on the benefit side? Do you all agree to that?

Ms. FEDER. I don't think so.

Mr. DONNELLY. You don't?

Ms. FEDER. No. I don't know what new entitlement program—if you are talking about the development of the catastrophic benefit?

Mr. DONNELLY. Exactly.

Ms. FEDER. Well, I guess I couldn't say that. I think that we can afford to improve Medicare benefits without necessarily introducing a major ability to pay concept into the Medicare problem.

Mr. DONNELLY. Then how do you suggest we pay for it?

Ms. FEDER. I think several financing sources have been proposed this morning.

Mr. DONNELLY. Then you must agree with me, Dr. Wilensky, unless I am missing something.

Ms. WILENSKY. Yes. No, I think that your comment that you can't have a new—

Mr. DONNELLY. Well, I happen to believe that we can't create new entitlement programs without putting some sort of means test or ability to pay mechanism in it, both short term and long term.

Ms. WILENSKY. I think that what you are asking us, is if you expand benefits as this proposal does, will you need to have a separate financing mechanism that goes along with it. You can't simply expand the benefits and not have a specific financing mechanism that accompanies the plan. In this case including the value, of the publicly funded portion of Medicare, into the beneficiaries taxable income matches the expanded benefit with an expanded funding source. To not do that would be financially irresponsible.

I believe this was the question you asked, in which case I agree with you.

Mr. ETHEREDGE. I certainly agree with the principle that we need to begin to look at means relating benefits, especially for the elderly because they are now such a differentiated group, much more so than ever before.

If you are down at the \$5 a month level, which is where the administration is, putting in a new means testing mechanism hardly seems worth it for that small a change. When one gets to \$15 a month, and certainly to broader restructuring of Medicare over the long term, then it becomes much more important that those bur-

dens be shared equitably, because they become real burdens if they are not means related.

Mr. DONNELLY. Do you think we should means test the existing Medicare program?

Mr. ETHEREDGE. I do not. I think that the benefits should remain the same for everyone, but that the financing ought to be increasingly from the over-65, and that that financing ought to be increasingly resource or means related.

So the net cost, the net result, is the same as you suggest, but I would do it through the financing side or the tax side rather than trying to adjust the benefits by income class.

Mr. DONNELLY. Is that because it is easier administratively?

Mr. ETHEREDGE. It would be an administrative nightmare to try to redo Medicare. To put in income-related testing, you would have to go outside the income tax system because less than half of the elderly now pay income tax. And trying to set up a separate means testing system for the elderly, for what they think is an entitlement, I think is a very serious step.

Ms. WILENSKY. There definitely are administrative problems which would need to be worked out. Nonetheless, giving serious consideration to income relating the benefits is something we are going to end up doing in the next decade because of the demographic changes that we are going to be facing.

I think we will need to end up using the income tax system. To set up any other kind of means test would be impossible, but it is not clear to me that given the relatively stable income of the elderly from year to year that using the income tax with all of its imperfections, is inappropriate. It is in fact, the mechanism we use to define ability to pay for most purposes other than welfare. Given the major shifts in demography and the growth of the elderly population, there will be tremendous pressure to have at least the financing means tested.

My concern is that mean testing the financing still means that very large amounts of money are transferred through the public system; that is, you publicly finance almost all hospital and physician expenditures and then financing these expenditures through a variety of mechanisms. This is not a costless transfer of funds. On net, you can say that you could have either smaller amounts of Government financed expenditures or finance a larger total but do it within a different mix of financing and in balance, and that the net impact is the same.

But moving all that money through the public fisc is not a costless exercise. So I think that if the appropriate mechanisms can be made operational, and we can income-relate the benefits with the use of the income tax system, we ought to give it serious consideration.

Mr. DONNELLY. Doctor?

Ms. FEDER. I would agree this time with the feasibility of a program that would income relate the benefits, and from an equity perspective I think that that might be a very important consideration and do agree with Dr. Wilensky that it is a feasible thing to do.

Mr. DONNELLY. Thank you, Mr. Chairman.

Chairman STARK. Thank you. And I would like to thank the panel very much for their participation this morning.

Our third panel, representing beneficiary groups, consists of John Denning, the president of the AARP—American Association of Retired Persons; William Hutton, executive director of the National Council of Senior Citizens; Mr. Ron Pollock, the executive director of the Villers Advocacy Associates.

Gentlemen, welcome to the committee. If you would like to proceed with your testimony, summarizing or expanding in any manner you are comfortable with, please do so.

Mr. Denning.

STATEMENT OF JOHN DENNING, PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. DENNING. Thank you, Chairman Stark.

On behalf of the more than 24 million members of the American Association of Retired Persons I wish to thank you for this opportunity to state the association's views on problems of catastrophic illness. The association commends you, Mr. Chairman, and Mr. Gradison, for your work in the development of the Medicare Catastrophic Protection Acts of 1987.

I will focus my remarks this morning on four areas: the major source of catastrophic costs for older Americans; acute care costs; the association's response to the administration's catastrophic proposal, and to the Stark-Gradison proposal; and the association's own recommendations.

Let us be clear this morning about the source of catastrophic costs for this country's senior citizens. Indisputably, the most critical need for catastrophic protection for older Americans is for help with the cost of long-term care.

Our first chart, you will notice, indicates nursing home stays account for 80 percent of the expense incurred by older people who experience very high out-of-pocket costs for health care. For most older Americans, acute care illness is less likely than long-term illness to result in a catastrophic burden.

But Medicare's coverage of acute care is by no means complete. Beneficiaries must pay deductibles and coinsurance for Medicare covered services, and must bear the full weight of the cost of noncovered medical services and goods.

How do beneficiaries protect themselves from these gaps in Medicare's coverage which cumulatively can be devastating? About 70 percent of enrollees purchase private supplemental insurance plans, but there is great variability in the coverage offered by such medigap plans. They seldom provide protection against the cost of prescription drugs, balance billing by physicians, dental, optical and eye care, and nursing home care.

Further, their cost in premiums may be high relative to the benefit returned to the insured.

Who among the elderly are most vulnerable to acute care catastrophic costs? The answer must include the 21 percent of Medicare beneficiaries whose insurance protection is not supplemented by medigap or Medicaid.

As our second chart shows, these individuals tend to be old, poor and frail. Another group of particular concern is the 44 percent of the poor elderly Americans who feel compelled to buy medigap insurance but who must surely forego certain day-to-day essentials in order to do so.

Secretary Bowen's catastrophic proposal represents an important first step in the development of a viable plan to protect Medicare beneficiaries from acute care catastrophic costs. But his proposal, which is now the administration's proposal, is a minimal one. Its \$2,000 cap on coinsurance and deductibles would hardly protect an elderly person of limited means from financial catastrophe.

Further, the plan offers no protection for extended nursing home care, balance billing by physicians, prescription drugs, and vision and hearing care, the administration's proposal strengthens Medicare, but it is misleading to label it a "catastrophic protection plan."

The newly introduced Stark-Gradison bill improves upon the administration's proposal by lowering the cap and by introducing some improvements in transitional care. Although it does not address long-term care or prescription drug costs, it does serve as a useful foundation on which to build.

The Stark-Gradison benefits are financed through the taxation of the actuarial value of Medicare. While the association encourages the exploration of innovative financing approaches to fund catastrophic protection, we are not convinced that the modest benefit improvements in the Stark-Gradison plan justify the adoption of such a radical change in Medicare's existing financing mechanism. We believe that other revenue options should be exhausted before consideration of this approach.

The association advocates the development of a benefit improvement that incorporates a catastrophic cap but is more comprehensive than either the administration's plan or the Stark-Gradison plan. In our opinion, the AARP proposal better balances the need for acute care protection with the need for long-term care protection. It also includes critical protection for low-income beneficiaries. We believe that our proposal represents an earnest attempt to fulfill the President's pledge to protect older Americans against catastrophic health care costs.

The association's package includes three parts: our acute care proposals include: one hospital deductible per year; the elimination of hospital coinsurance and lifetime limits; a \$1,000 cap on Medicare part B cost-sharing; a prescription drug benefit; and Medicaid improvements which we view as inseparable from the cap.

For transitional care, we recommend improvements in the skilled nursing facility benefit, and home health benefit, and a new respite benefits.

In the long-term care component, we would include protection against spousal impoverishment and the expansion of home and community-based services.

To pay for these improvements, we recommend an assortment of potential financing sources including doubling the tobacco tax, extension of HI coverage to State and local workers, and a premium.

The association cannot in good conscience support filling the gaps in Medicare's coverage, while at the same time ignoring inad-

equacies in health insurance coverage for America's workers and its children. And finally, the congressional debate on catastrophic illness has raised the hopes and expectations of the American people. Beneficiaries are apt to take Congress at its word and believe that it is providing truly catastrophic coverage. Beneficiaries must not be disappointed. We must let them know exactly what we are doing, what kind of benefits they will receive and what the benefit is going to cost them.

I appreciate the opportunity to testify this morning.

Chairman STARK. Thank you.

[The prepared statement follows:]

STATEMENT OF JOHN DENNING, PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS

Thank you, Chairman Stark. On behalf of the more than 24 million members of the American Association of Retired Persons, I wish to thank you for this opportunity to state the Association's views on the problem of catastrophic illness.

Before I begin, however, I would like to say that the Association is gratified by the current congressional and public interest in the problem of high cost illness and its impact on the citizens of this country. We believe that the current public debate on catastrophic illness will lead to a more complete and more accurate understanding of the problem; the debate itself is, in our view, a critical step in the development of workable, appropriate solutions to a complex but hardly intractable social problem.

Let me say, at this point, that the Association commends Congressmen Stark and Gradison for their work in the development of the Medicare Catastrophic Protection Acts of 1987 (H.R. 1280 and H.R. 1281).

I will focus my remarks this morning on four areas: the major source of catastrophic costs for older Americans; the nature of the acute care catastrophic experience among older Americans; proposals by the Administration and the Chairman, ranking member, and other members of this subcommittee to address elements of the catastrophic problem; and finally, recommendations by the Association, building in part upon the work of Secretary Bowen, Chairman Stark, and Congressman Gradison.

THE MAJOR SOURCE OF CATASTROPHIC COSTS FOR OLDER AMERICANS

Let us be clear this morning about the source of catastrophic costs for this country's senior citizens. Indisputably, the most critical need for catastrophic protection for older Americans is for help with the costs of long-term, chronic illness. As chart 1 indicates, nursing home stays account for over 80% of the expenses incurred by older people who experience very high out-of-pocket costs for health care (over \$2,000 per year).

The need for long-term care leads almost inevitably to an unmanageable financial burden because the costs of care -- be it in an institution or in the home -- are often enormous. Chart 2 shows the amount that an individual would pay for a 12-month stay in a nursing home and for modest medical expenses during that year. At more than \$20,000 each year, few families could survive such expenses without severe financial hardship. Medicare and private insurance combined pay only a miniscule proportion of nursing home costs (less than 3% in 1985). More than half of nursing home costs are paid out of the pockets of residents or their families. Most of the remaining costs are paid under Medicaid, a means-tested welfare program. To qualify for Medicaid, one must either be poor or reduced to poverty in the process of trying to pay for care.

Few people can afford the expense of an extended nursing home stay, so many eventually end up on Medicaid, but only after financial catastrophe has occurred. Fully one-half of Medicaid dollars for nursing home care is spent on behalf of persons who enter nursing homes as private paying residents. The process of "spending-down" one's income and depleting one's assets to qualify for Medicaid can occur very quickly. A 1985 study conducted for the House Aging Committee found that approximately 2/3 of single older persons and 1/3 of older couples in Massachusetts were impoverished after only 13 weeks in a nursing home.

As such statistics indicate, the impoverishment of a spouse in the community in order to finance the care of an institutionalized mate is one of the most serious problems facing older couples today. To be eligible for Medicaid, couples must often spend-down their combined income and assets, leaving one spouse - usually the wife - destitute. Many of the same women who are caught in the spend-down problem have spent years taking care of ill and disabled husbands at home.

Personal care services of indefinite duration in the home are not covered at all by Medicare, and the amount and type of home care provided under Medicaid is extremely limited in most states. Even those who can afford to pay for home health and other in-home services face often insurmountable barriers in locating competent, trained personnel. As a result of both limited access to home care and the very high expense of nursing home care, many older persons live in fear of becoming a burden on their families, or being forced to enter a nursing home and spend their lifetime savings in order to pay for care.

THE ACUTE CARE CATASTROPHIC EXPERIENCE AMONG OLDER AMERICANS

For older Americans who have Medicare coverage, an acute care illness is less likely to result in a catastrophic burden than a long-term illness. But Medicare's coverage of acute care is by no means without significant gaps, gaps which if not supplemented by other forms of insurance, leave individuals vulnerable to devastating medical costs. Chart 2 shows that a Medicare beneficiary with two hospital stays would, on average, incur out-of-pocket expenses that would total nearly \$3000 without private supplemental insurance and would even result in expenses over \$1600 with an average insurance policy.

Medicare beneficiaries' liability for acute care medical costs consists of two components: (1) Medicare cost-sharing requirements (i.e., deductibles and coinsurance) for covered services, and (2) expenditures for non-covered medical services and goods. It is important to distinguish between these two categories of liability since most of the catastrophic "cap" plans that have been proposed permit the former (coinsurance and deductible amounts) to be counted toward the cap but exclude the latter (expenditures for non-covered services and goods). And the second category of liability is by no means insignificant; we estimate that, on average, for every \$1.00 beneficiaries incur in coinsurance and deductibles, they spend an additional \$.50 to \$1.00 for non-covered services and goods.

1. Deductible and Coinsurance Liability

Under Medicare Part A, beneficiaries are required to pay a hospital deductible in each benefit period approximately equal to the cost of one day of hospital care (\$520 in 1987). They are also responsible for coinsurance for days 61 through 90 equal to one-fourth of the hospital deductible. For each lifetime reserve day (days 91 through 150), beneficiaries are required to pay an amount equal to one-half the Part A deductible, or \$260 per day in 1987. While there is no deductible for skilled nursing facility (SNF) services, Medicare beneficiaries this year will pay \$65 per day to satisfy coinsurance requirements for days 21 through 100 in a SNF.

Approximately 23% of Medicare enrollees are admitted to a hospital at least once in a given year. But only about .5% of Medicare enrollees (158,000 in 1984) use more than 60 hospital days in a year, thereby triggering hospital coinsurance requirements.

In 1985, Medicare beneficiaries incurred \$3.2 billion in Medicare hospital deductible and coinsurance liability. This amount represented an increase in such aggregate liability of more than 100% between 1980 and 1986. The largest portion of total Part A cost-sharing liability is attributable to the Part A hospital deductible.

Beneficiaries also share heavily in the cost of Medicare Part B services. Each beneficiary must meet a \$75 annual Part B deductible, and is also responsible for 20% of the amount that Medicare deems "reasonable" for a particular Part B service. (In addition, beneficiaries whose doctors do not accept assignment are fully responsible for the amount their doctor charges above the Medicare-approved rate.)

Cost-sharing requirements under Medicare Part B represent a far greater financial burden on Medicare beneficiaries than do cost-sharing requirements under Part A. In 1986, Medicare beneficiaries incurred \$5.7 billion dollars in Part B coinsurance liability and \$1.7 billion dollars in Part B deductible liability. The most striking rate of increase in physician-related liability has occurred in coinsurance liability which in the aggregate has risen by 170% since 1980. Moreover, increases in Part B coinsurance expenditures have far outpaced increases in Social Security benefits.

Whereas only about one-fourth of Medicare beneficiaries will incur liability from the use of hospital services in a given year, 80% will incur liability from the use of physician services during the same period. Further only .5% of beneficiaries will trigger hospital coinsurance costs, but fully 60% of beneficiaries will incur coinsurance liability for physician services.

2. Medical Services and Goods Not Covered by Medicare

In addition to Medicare's cost-sharing requirements for covered services, beneficiaries also face significant out-of-pocket costs for those acute care medical services and goods which Medicare does not cover or which, in the case of certain services, are subject to Medicare's durational limits.

These acute care services and goods include:

- o Outpatient prescription drugs
- o Balance billing by physicians on non-assigned claims
- o Dental services/products
- o Optical services/products
- o Hearing care services/products
- o Routine physician examinations, influenza shots, Pap smears.

Out-of-pocket expenditures for these non-covered acute care services and goods can be staggering: more than \$7 billion for outpatient prescription drugs in 1986; almost \$3 billion for balance billing by physicians; more than \$2.3 billion for dental care; and more than \$1.4 billion for eye care.

3. Medigap's Role in Protecting Beneficiaries Against Catastrophic Costs

The gaps in Medicare's coverage, particularly its cost-sharing requirements, have led to the development of private supplemental insurance plans, so-called "Medigap" policies. About 70% of Medicare beneficiaries are covered by such plans. Since the enactment of the Baucus amendment in 1980, Medigap plans are

required to cover: (1) hospital coinsurance; (2) 90% of Part A expenses after exhaustion of the lifetime reserve to a lifetime limit of 365 additional days; and (3) the 20% coinsurance on Medicare Part B services. Such plans are not required to cover either the hospital or physician service deductible, although most offer coverage of the former. Finally, the plans may impose their own deductible of up to \$200 per year for Part B coverage.

In spite of the Baucus amendment, there is great variability in the depth and scope of coverage provided by Medigap plans. Most Medigap plans provide little or no coverage of prescription drugs, balance billing by physicians, dental services, and extended nursing home care. Moreover, the Baucus amendment does not apply to employment and labor organization-related group insurance, conversions from group plans to individual policies, and policies in effect before July 1, 1982. Finally, some plans may be very costly relative to the benefit returned to the insured.

It should be noted that supplemental coverage through a Medigap plan is positively correlated with income and education. Yet almost half of elderly people with less than \$5000 per year in family income purchase Medigap plans (see chart 3). Even if the coverage selected is modest, the premium payments for such plans must constitute a terrible drain on already meager resources.

Let me at this point clarify the Association's position on the ability of the private insurance industry to protect older Americans from the inadequacies of Medicare's coverage. The Association offers its members a Medicare supplemental insurance plan that fills many of the existing gaps in Medicare coverage. We believe, however, that filling such gaps through the Medicare program is inherently the most efficient way to insure against acute care catastrophic costs. Accordingly, we welcome any meaningful improvements in the Medicare program that will reduce the need for supplemental insurance plans or make them unnecessary.

4. Medicaid's Role in Protecting Beneficiaries Against Acute Care Catastrophic Costs

It is reassuring to believe that the Medicaid program serves to protect elderly beneficiaries from potentially catastrophic acute care out-of-pocket expenditures. But this is not necessarily the case. The Congressional Budget Office (CBO) reports that in 1986 only 27% of elderly people with family incomes below \$5000 were covered by Medicaid (see chart 3). How can this be? We have only to look to the variability in Medicaid's eligibility requirements across states for an answer. There exists no national mandatory income standard for Medicaid eligibility, no mandated coverage of the "medically needy", and no uniformity in eligibility for a Medicaid "buy-in" of Medicare Part B coverage.

5. The Vulnerable Elderly

Who among the elderly are most vulnerable to acute care catastrophic costs? Surely the answer must include those who are not able to afford Medigap coverage, but who also do not qualify for Medicaid coverage. Such individuals tend to be frail, low-income, and uniquely vulnerable to the cumulative financial burden resulting from Medicare coinsurance and deductibles and from the costs of all non-covered services and goods. For nearly 21% of the elderly, Medicare represents the only source of protection (see chart 4).

A second group worthy of particular concern includes the poor/near poor who feel compelled to buy Medigap insurance but who can ill afford it. One can only surmise that such individuals must forego certain day-to-day essentials in order to purchase such protection (see chart 3).

THE ADMINISTRATION PROPOSAL

The Association is encouraged by the demonstrated interest of the Administration and the Congress in finding solutions to the problem of high cost illness for older Americans, although we are disappointed over the almost exclusive preoccupation with costs arising from acute care illness. The Administration proposal based on earlier recommendations of Secretary Bowen addresses only acute care costs, providing beneficiaries with unlimited hospital coverage subject to two deductibles each year and "capping" annual out-of-pocket expenditures for Medicare coinsurance and deductibles at \$2000.

The Association recognizes that, through his recommendations to strengthen the Medicare program, Secretary Bowen took an important first step in the development of a viable plan to protect beneficiaries against acute care catastrophic costs. Nevertheless, it must also be recognized that the Secretary's catastrophic proposal -- now the Administration's catastrophic proposal -- is a minimal one. The \$2000 cap on coinsurance and deductibles would hardly protect an elderly person of limited or even moderate means from financial catastrophe. Nor is it likely to persuade Medigap holders to drop their supplemental plans and self-insure for the first \$2000 in coinsurance and deductibles.

Further, under the Administration plan, no out-of-pocket costs for the following services and products would count toward the annual cap: long-term nursing home care, out-patient prescription drugs, dental services, home health services, physical examinations, balance billing by "non-assigned" physicians, and optical supplies and services. The Administration plan may thus offer some improvement in Medicare's coverage, but it is misleading to suggest that it would provide older Americans with protection against catastrophic health care costs.

THE STARK/GRADISON PROPOSAL

Secretary Bowen in developing his catastrophic proposal has given a matter of critical social significance visibility and credibility. He deserves credit for animating discussion and debate on the full range of catastrophic illness issues.

Catastrophic proposals such as that developed by Chairman Stark and Congressman Gradison advance this critical exchange of diverse ideas and help us to refine the elements of a workable, comprehensive plan. As we understand the Stark/Gradison proposal, it would differ from the Administration's plan at a number of points, both with reference to benefit design and financing. It would: require but one hospital deductible each year; set a cap on Part B coinsurance and deductibles of \$1000 per year indexed to the COLA; extend SNF coverage to 150 days; reduce SNF coinsurance and transfer it to the first seven days of care; extend the hospice benefit; and finance the package through taxation of portions of the actuarial value of Medicare Parts A and B.

In terms of its benefit design, the Stark/Gradison plan effectively lowers the acute care catastrophic cap vis a vis the Administration plan, and introduces modest improvements in benefits bridging the gap between acute and long-term care. While it does not address the two largest categories of out-of-pocket expenditures for non-covered services borne by beneficiaries -- namely long-term care and prescription drugs -- it does advance the evolutionary movement toward a more comprehensive catastrophic protection package, and, as such, serves as a useful foundation upon which to build.

The financing option which Chairman Stark and Congressman Gradison have chosen to fund their catastrophic plan represents a radical departure from the financing mechanisms which presently support the Medicare program. While we encourage the exploration of innovative financing approaches to fund catastrophic protections, we are not convinced that the modest benefit improvements in the Stark/Gradison package justify the adoption of such a radical change in existing financing mechanisms. We believe that other revenue options should be exhausted before we consider such an approach.

AARP'S CATASTROPHIC PACKAGE RECOMMENDATIONS

One of the dilemmas policymakers face in attempting to set a protective "cap" on catastrophic costs is pinpointing the appropriate level for such a cap. Set the cap high, and the benefit can be financed without great difficulty; but as is clear from chart 5, few are protected under such an arrangement. As one pushes the cap down, the protective scope of the cap expands but the cost rises proportionately. Severely restrict the elements of liability which count toward the cap, and the plan becomes more affordable; the danger in this arrangement, of course, is that beneficiaries may wrongly assume that their total out-of-pocket liability in a given year will not exceed the cap level. As they gradually come to realize that a full range of essential medical services and products do not even count toward the "catastrophic" cap, they are apt to feel disappointed, if not duped.

It is important, then, that any plan that lays claim to providing any level of catastrophic protection must identify and appropriately address actual sources of vulnerability. The Association believes that long-term care is the real source of catastrophic costs for older Americans, including middle-income older Americans. We also believe that acute care costs -- for both coinsurance and deductibles as well as non-covered services and goods -- can threaten the financial security of many older Americans, but is potentially devastating to low-income elderly.

Given these concerns, the Association advocates the development of a benefit improvement that incorporates a catastrophic cap but is more comprehensive than either the Administration plan or the Stark/Gradison plan and that, in our opinion, better balances the need for acute care catastrophic protections with the need for long-term care catastrophic protections. It also includes critical protections for low-income Medicare beneficiaries.

We do not delude ourselves in advancing the following set of recommendations that we have solved the catastrophic problem for older Americans. We do believe that in many respects our proposals expand, refine, and improve upon the efforts of others who have also grappled with this complex issue. Our proposals represent an earnest attempt to fulfill the President's pledge to protect Americans against catastrophic health care costs.

The benefit structure of the Association's package can be divided into three pieces:

1. Acute Care
2. Transitional Care
3. Long-term Care

Under the acute care component, we propose the following:

- o One hospital deductible per year indexed to the COLA;
- o Elimination of hospital coinsurance;
- o Elimination of lifetime limits on hospital care;

- o A \$1000 cap on Medicare Part B cost-sharing (i.e., deductibles and coinsurance);
- o A prescription drug benefit with a \$200 annual deductible and a \$1.00 copayment on each filled prescription;
- o Improvement in the Medicaid program through the establishment of a uniform mandatory income standard for Medicaid eligibility, expansion of "medically needy" coverage, and expansion of coverage through the Medicaid "buy-in" of Medicare Part B services. We view this element of the package as inseparable from the cap which, at \$1000, is too high to adequately protect low-income beneficiaries.

Under the transitional care component, we recommend:

- o Elimination of SNF coinsurance;
- o Elimination of the three-day prior hospitalization requirement for SNF eligibility;
- o An expanded home health care benefit;
- o A respite benefit (carrying a 50% copayment) to provide assistance to caregivers.

Our long-term care component would include:

- o Protections against spousal impoverishment; and
- o Expansion of home and community-based waiver services; and
- o Exploration of the feasibility of capping out-of-pocket costs associated with long-term care.

The Association recognizes that, given a burgeoning federal deficit, the kind of improved benefit package we are recommending must be self-financed. Further, results of a recent AARP survey indicate a willingness among a majority of older people to pay increased premiums in return for significantly expanded benefits. Nevertheless, the full burden of the costs of the improved package we are advocating should not fall exclusively upon the elderly. To pay for the improvements we have described above, we propose using an assortment of revenue sources, some targeted on improvements in the Medicare program and others targeted on Medicaid remedies. These potential revenue sources include:

<u>Potential Revenue Source</u>	<u>Target</u>	<u>Estimated Yield</u>
o Doubling of the tobacco tax	Medicaid	\$3.9 billion
o Extension of AI coverage to state and local employees	Medicare	\$1.6 billion
o Increase in the Part B Premium not to exceed an additional \$10/month	Medicare	Up to \$3.7 billion
o Rebasing DRGs	Medicare	\$3.0 to \$4.4 billion
<hr/> Total: \$12.2 to \$13.6 billion		

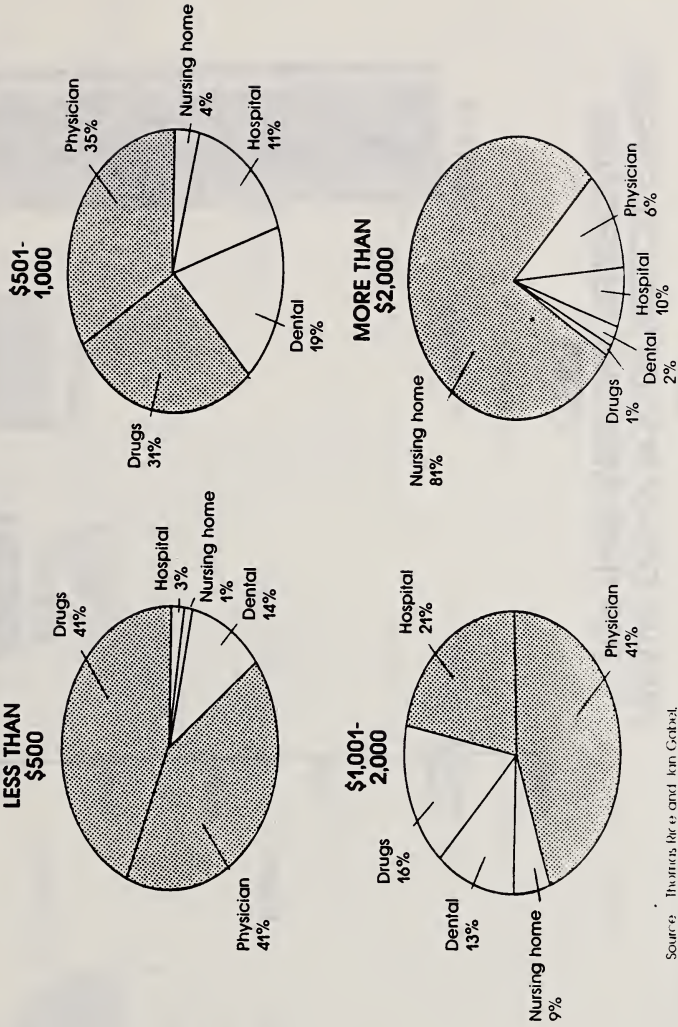
The package we have proposed, like those proposed by the Administration and Congressmen Stark and Gradison, would probably not represent a replacement for a typical Medigap plan. We believe, however, that responsible private insurers would respond with a corresponding offset (i.e., reduction) in Medigap premiums to match their reduction in risk exposure. Thus, the net additional cost in premiums to the 70% of Medicare beneficiaries carrying supplemental insurance could be minimal. As a complementary measure, our recommended Medicaid improvements would serve to protect those not currently covered by Medigap or Medicaid.

I would like to conclude my remarks this morning with two observations. First, we focus our attention here today on the plight of older Americans, many of whom struggle daily under the crushing weight of catastrophic medical costs. Initial action to address their plight is appropriate and, indeed, long overdue. But let us not forget the suffering of some 37 million Americans under the age of 65 who have neither public nor private health insurance. Surely a nation as richly blessed as ours in material wealth, wisdom, and compassion can summon the resolve to correct this terrible and intolerable social wrong. For our part, we cannot in good conscience support filling the "gaps" in Medicare's coverage, while at the same time ignoring inadequacies in health insurance coverage for working Americans and our nation's children.

Finally, as we convene this morning, we do so with the realization that Congress is poised for action on catastrophic protections for older Americans. Whatever the outcome of this year's initiative on catastrophic illness, let us be scrupulously correct in characterizing to the American public what we have accomplished and, perhaps more importantly, what we have not accomplished in our efforts to come to grips with one of this country's most pressing social needs.

CHART 1

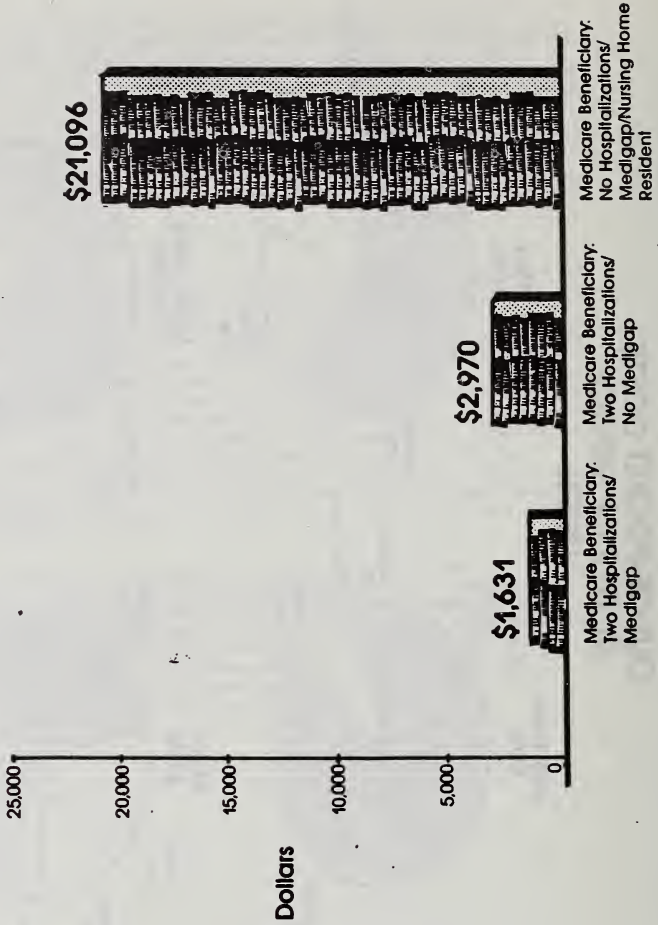
OUT-OF-POCKET COSTS BY TYPE OF SERVICE (1980)



Source: Theaters for and Jan Gebel,
Health Affairs, Fall 1986.

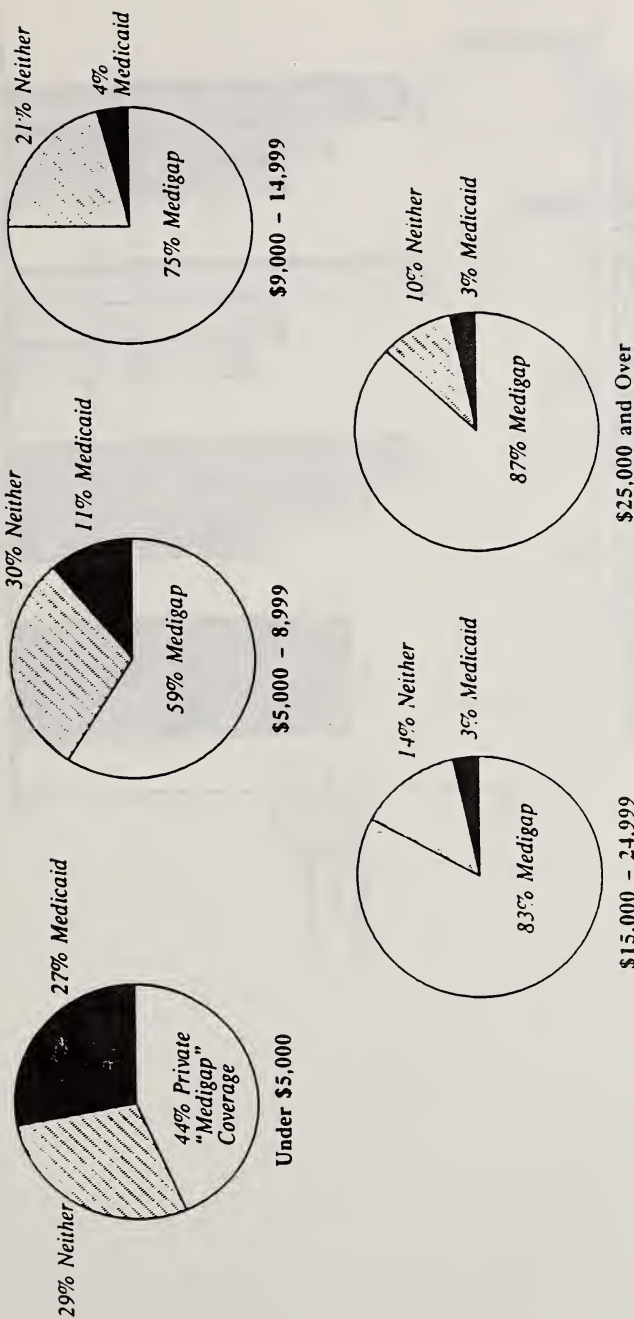
CHART 2

ANNUAL OUT-OF-POCKET MEDICAL EXPENSES FOR THREE MEDICARE BENEFICIARIES (1987)



Source: Based on Congressional Budget Office preliminary estimates

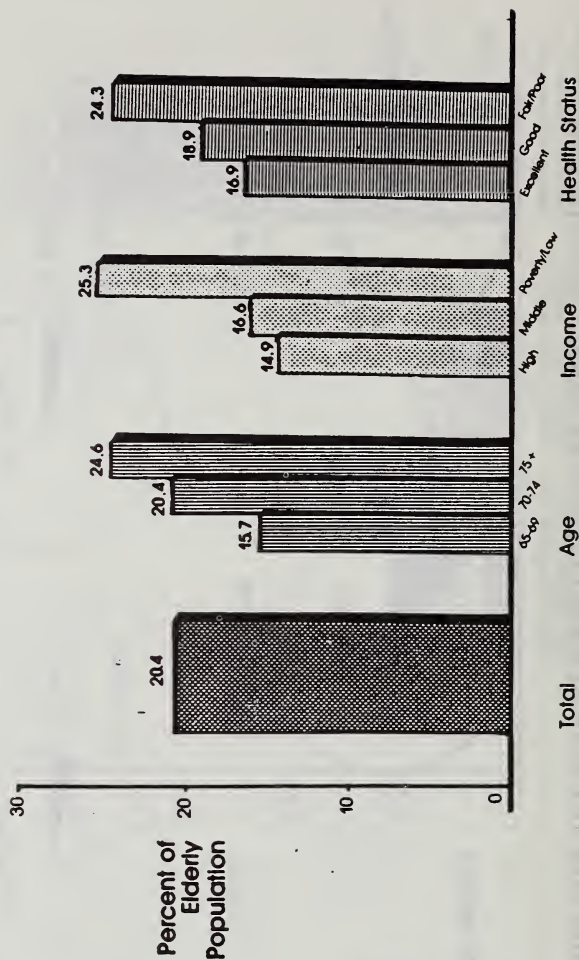
MEDIGAP COVERAGE FOR THE ELDERLY POPULATION BY FAMILY INCOME, 1986



Source: Congressional Budget Office.

CHART 4

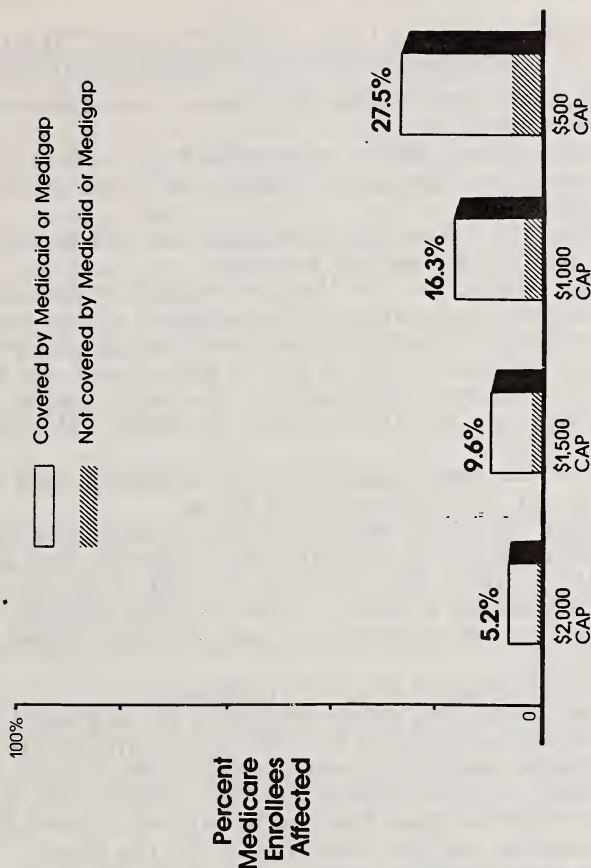
ELDERLY POPULATION WITHOUT PRIVATE HEALTH INSURANCE OR MEDICAID



Source: National Center for Health Services Research

CHART 5

CATASTROPHIC CAPS: WHO BENEFITS? (1988)



Source: CBO Estimates

Chairman STARK. Mr. Hutton.

**STATEMENT OF WILLIAM R. HUTTON, EXECUTIVE DIRECTOR,
NATIONAL COUNCIL OF SENIOR CITIZENS**

Mr. HUTTON. Yes, sir. Mr. Chairman, I would like to submit my entire testimony.

Chairman STARK. Without objection, it will appear in its entirety in the record, and you may enlighten us in any manner that you are comfortable.

Mr. HUTTON. If I could only enlighten, it will be great. But I am afraid that I just try and say my piece.

Anyway, thank you for the opportunity to testify. As always, your leadership and that of the members of this committee remains invaluable to senior citizens, and we applaud your efforts in this particular area, which is a very serious one, and your obvious interest in seeking to solve some of the very complex problems of catastrophic care for this nation's 30 million Medicare beneficiaries.

We hope our own suggestions will be helpful, and we sincerely hope that you will continue to call on us.

According to figures we have seen, an estimated 96 percent of older people will never reach the \$2,000 cap proposed under the administration's plan. The National Council of Senior Citizens has specific suggestions to make on how we might provide coverage for the three types of catastrophic costs which are faced by this Nation's elderly.

One, the coverage of long-term care costs.

Two, providing first dollar protection for low and lower income elderly, as well as covering the costs of prescription drugs.

And finally, permitting more health costs to count toward the catastrophic cap, thus permitting more of the sick to be helped. There are concrete steps that can be taken to make long-term care more accessible and less catastrophic for the elderly. Specifically, the 3-day hospitalization requirement for Medicare-covered skilled nursing care should be eliminated along with all Medicare skilled facility copayments. A remedy to the problem of spousal impoverishment, that you heard something about this morning should be made an integral part of a catastrophic package. And Medicare home health care benefits should be more clearly defined.

To address the need for first dollar health care coverage for the poor and the near poor, States should be required, through the Medicaid program and possibly with an enhanced Federal match, to cover Medicare cost-sharing requirements for all seniors below the Federal poverty line.

Congress should also explore the possibility of an optional buy-in to Medicaid for people over the age of 65 but above the Medicaid eligibility level.

In addition, Mr. Chairman, we believe that ample justification for the inclusion of a prescription drug benefit for the general Medicare population. These costs have risen dramatically and there is little insurance protection available.

The lower catastrophic protection cap such as the one proposed in your legislation, Mr. Chairman, also helps us achieve the goal of

increased coverage for out-of-pocket costs for the rest of the elderly population.

NCSC commends your action in this area and your recognition of the burden that a \$2,000 cap would place on many beneficiaries. We would recommend that excess physician charges and prescription drug costs should also be included to reach the cap.

Who should pay for the added benefit? In this case we think the answer is a fairly simple one. The burden should be shared. Since 1980, domestic programs serving the poor and the elderly have sustained deep cuts even as the deficit has grown. The Medicare program's cuts already adopted will cost Medicare beneficiaries \$14 billion over the next five years.

Very real savings can and should be found through the providers of health care in our country, and, in fairness, savings from these cuts should be targeted to pay for any Medicare benefit expense.

NCSC urges the Committee to consider the possibility of rebasing the DRGs to factor in more cost and efficiency data and using the resulting savings, which the CBO estimates at \$4.4 billion for the first year, to help finance new benefits for the elderly.

NCSC recognizes that the elderly should participate to some degree in financing any kind of comprehensive benefit extension. Although we do not support the taxation of entitlements, we applaud your recognition of the need for financing the program without overburdening the poor.

NCSC shares that same commitment and we would like to work with you in exploring other ways to finance progressively an enhanced benefit package. One of the very real problems we see with an actuarial value test is the precedent it sets for taxing other entitlement programs and the possibility of counting such income, and I put that word in quotes, for determining eligibility in low-income programs such as food stamps, low-income energy assistance, and so forth.

In addition, NCSC advocates the inclusion of State and local employees under the Medicare program since the majority of these citizens eventually rely on the benefits and protections provided by the Medicare program. We believe it is entirely fair that they also be required to take part in the financing of the program. Revenues generated by this proposal should be used to finance catastrophic coverage.

Finally, we must in fairness recognize the fact that the plans under discussion deal only with the elderly population. Even as advocates for the elderly, we recognize and sympathize with the plight of 37 million younger Americans who have no health insurance at all.

Mandating employers to provide health insurance is one step. But we should also consider requiring States to provide Medicaid coverage to all those living below the poverty line. A major step was taken in this direction in the last Congress, and we must continue to press for such a Medicaid expansion.

Thank you very much, Mr. Chairman.

Chairman STARK. Thank you, Mr. Hutton.

[The prepared statement follows:]

CATASTROPHIC HEALTH CARE and the ELDERLY

Testimony Presented Before the
Health Subcommittee
of the House Ways and Means Committee

By

William R. Hutton
Executive Director
National Council of Senior Citizens

Thank you, Mr. Chairman, for holding this important hearing on catastrophic health care. You are certainly to be commended for your work in this area. Your leadership is extremely important on this issue and we look forward to working with you.

Catastrophic health care coverage is a very important issue, but it is not a new one, as you well know. I have been presenting testimony before Committees of this and previous Congresses for the past 20 years. I have listened to testimony by the Secretaries of Health, Education and Welfare and Health and Human Services. In the 20 years that we have been discussing catastrophic illnesses and how to pay for them, we have always ended up with another study which lasts for a year and then is forgotten. We are now faced with a window of opportunity to make genuine improvements in Medicare, the likes of which we have not seen for many years--and may not see for many more.

Catastrophic costs generally look very different for the elderly than they do for the rest of the population. The elderly face three types of catastrophic costs: costs associated with the need for long-term care; out-of-pocket costs associated with both covered and uncovered health services, but particularly associated with the high cost of prescription drugs for middle and low-income people; and, catastrophic costs associated with long-term hospitalization where neither Medicaid nor Medigap offers protection. Unfortunately, the Administration's plan would not adequately address any of these crucial catastrophic health care costs faced by older Americans.

One of the single greatest catastrophic events an older American can face, both emotionally and financially, is being placed in a nursing home. Nursing home costs average \$22,000 per year. Altogether, the elderly, in 1986, spent out of their own pockets \$37.3 billion on health care, \$16 billion of which was spent on nursing homes alone. In this way, 1.6 million of the nation's elderly spent \$16 billion--fully one-half of the nation's total nursing home bill--out of their own pockets.

This is an enormous burden that the elderly and their families are forced to shoulder themselves. While most of the elderly think the Medicare program or their Medigap policies will help with these costs, this couldn't be much farther from the truth. Medicare expenditures for care in skilled nursing facilities equal only two percent of total national nursing home expenditures, and only one percent of the total Medicare budget. Similarly, private insurance covers only one percent of the nation's nursing home bill. The grim reality that many elderly are forced to face is that protection from these tremendous costs does not exist until they have spent themselves into impoverishment.

In our opinion, continuing reliance on a public policy that withholds health care protection until and unless hard-working citizens pauperize themselves is not something in which we can take pride. Clearly, faced with the problem in both financial and human costs, we need to find a more rational, well-coordinated approach to covering the catastrophic health care costs associated with the need for long-term care.

The National Council of Senior Citizens understands the realities of Gramm-Rudman-Hollings and the chilling effect the Federal deficit has on good public policy generally, and good health care policy specifically, and so we realize that comprehensive coverage of long-term care costs within a public health program may not occur as soon as we would like. Intermediate steps can be taken in this area, however, and other very serious catastrophic costs faced by the elderly certainly can and should be included in a catastrophic package that aims to provide useful protections for the elderly.

Besides the obvious and tremendous costs of long-term care, Medicare cost-sharing and out-of-pocket costs, especially for prescription drugs, are catastrophic for many older Americans. The elderly today spend the same proportion of their incomes on health care as they did before Medicare and Medicaid were established in 1965. In 1984, average out-of-pocket health care costs for the elderly accounted for 15 percent of their incomes, the same level that existed before Medicare was enacted. Not including nursing home and other long-term care expenses, the average annual out-of-pocket health expenses for the elderly reached \$1,055 in 1984, more than three times the average amount (\$310) spent by other Americans.

The elderly are financially liable, under the Medicare program, for many out-of-pocket costs associated with Medicare covered services, including premiums, co-insurance charges, deductibles and costs above the Medicare "reasonable" charge limit. These costs have soared in recent years, leaving the beneficiaries with ever-heavier financial burdens to bear. The Part A hospital deductible, for example, increased by 155 percent in the past six years, from \$204 in 1981 to \$520 in 1987--an increase five times as great as the overall rate of inflation. The annual Part B premium for physician and other costs has increased by 86.5 percent in six years, from \$115.20 in 1981 to \$214.80 in 1987, and out-of-pocket costs for physician charges above the Medicare "reasonable" charge limit increased 286 percent, since 1977, to \$2.7 billion a year.

In addition to these costs for covered services, the elderly paid \$7 billion out of pocket in 1981 for many vital health care needs not covered by Medicare, including prescription drugs, eyeglasses, hearing aids, dental care and physical examinations. For 75 percent of the elderly population, prescription drugs represent the largest out-of-pocket expenses they will face. Many elderly individuals take four to five drugs a day and, on average, fill at least 12 prescriptions every year. In fact, while people over age 65 represent only 12 percent of the population, they take 30 percent of all prescription drugs used in this country. Unfortunately, unlike most other health care costs, prescription drug costs are not covered by private health insurance or by Medicare outside of the hospital. Medicaid will only cover the costs of prescription drugs for the indigent, or about six percent of the elderly's total drug expenditures. Only 20 percent of the elderly fall into one of these categories, leaving the remaining 80 percent to pay for these drugs out of their own pockets.

These costs are far from insignificant. The elderly's drug bill amounts to over \$6 billion annually. Payments for drugs represent 20 percent of the elderly's total out-of-pocket health care costs and average \$340 per person per year.

The extraordinarily high rate of inflation, and high rates of profit, in the prescription drug industry, are, in large part, accountable for the increased financial burden borne by the elderly in trying to pay for these costs. Last year, while medical care costs overall rose 7.7 percent, seven times as fast as the CPI, prices for prescription drugs outpaced all other medical costs by rising nine percent. Tranquilizers and sedatives, which are often prescribed for older people, posted the biggest price increase of 13.2 percent. At the same time, pharmaceutical corporations, in 1984, enjoyed profits of 13.2 cents on the dollar, compared to 4.6 cents for all manufacturers, and profits in this industry have traditionally outpaced the average profit for all other industries by two and even three times.

For elderly people not eligible for Medicaid, but too poor to purchase a Medigap policy, staggering health care costs have become overly burdensome. Nearly 2.2 million seniors living below the Federal poverty line (\$5,156 in 1985)--only 36 percent of the low-income elderly--are covered by Medicaid. Another 6.2 million near-poor seniors whose incomes are less than twice the Federal poverty line are also not covered by Medicaid. These seniors, who are the sickest and poorest, are exposed to health care costs equal to one-fourth to one-third of their income, or about \$1,300 per year.

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First-dollar coverage for the health care costs of this population is especially important since this population is much sicker than other elderly. Death rates are 50 percent higher than for Medicare beneficiaries. But, despite their greater health needs, they receive 35 percent fewer physician visits, 29 percent fewer prescription drugs and are 18 percent less likely to be admitted to a hospital.

Typical out-of-pocket costs for a moderate spell of illness for a senior whose income is lower than the Federal poverty line, but is not low enough to qualify for Medicare, can be catastrophic in the extreme.

Medicare Part A deductible	= \$520.00
Medicare Part B premium	= \$214.80
Medicare Part B deductible for physician services	= \$75.00, more if the physician does not accept Medicare assignment
Medicare Part B co-insurance on a physician bill of \$2,575.00	= \$500.00
Prescription drug bills	= \$500.00
Bills for eyeglasses, dental care, etc.	= \$250.00

Total typical health care costs equal \$2,003, out of an income below \$5,156.

At this rate, the poor and near poor elderly could not realistically be expected to pay an additional premium for catastrophic protection and out-of-pocket health care costs to reach a cap, such as the one proposed by the President. This group of very vulnerable and financially depressed seniors needs protection long before the cap is reached. The idea behind catastrophic protection should be to enable citizens to avoid being wiped out financially before protection begins. For these seniors, even ordinary out-of-pocket costs would cause them to be wiped out, or more likely, to avoid getting needed health care altogether.

Finally, there is the issue of the cap itself. According to figures we have seen, an estimated 96 percent of older people will never reach the \$2,000 cap proposed under the Administration's plan. The National Council of Senior Citizens has specific suggestions to make on how we might provide coverage for the three types of catastrophic costs faced by this nation's elderly: 1) coverage of long-term care costs; 2) providing first-dollar protection for low and lower income elderly, as well as covering the costs of prescription drugs; and 3) expanding the population assisted by the catastrophic cap.

Although the long-term care issue presents dramatic financing problems that we may not be ready to face, there are concrete steps that can be taken to make long-term care more accessible and less catastrophic for the elderly. Specifically, the three-day prior hospitalization requirement for Medicare-covered skilled nursing care should be eliminated, along with all Medicare skilled nursing facility co-payments; a remedy to the problem of spousal impoverishment should be made an integral part of a catastrophic package; and the Medicare home health care benefit should be more clearly defined.

Many of these proposals are part of a long-term care package Congressman Schumer is proposing for inclusion in the House budget resolution. The National Council of Senior Citizens is strongly in support of this package, as we feel it is doable, even in a tight fiscal era, and is long overdue in the benefits it would provide to senior citizens in need of long-term care.

To address the need for first-dollar health care coverage for the poor and the near poor, states should be required, through the Medicaid program and possibly with an enhanced Federal match, to cover Medicare cost-sharing requirements and provide prescription drug coverage to all seniors below the Federal poverty line. Medicaid coverage of these costs would provide payment of all deductibles, premiums and co-insurance amounts required by the

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Medicare program. It would also entitle beneficiaries to physician services through assignment and would provide adequate coverage of prescription drugs costs for this very poor segment of our society. Congress should also explore the possibility of an optional "buy-in" to Medicaid for people over the age of 65.

In addition, Mr. Chairman, we believe there is ample justification for the inclusion of a prescription drug benefit for the general Medicare population. As we have said, these costs have risen dramatically and there is little insurance protection available. Moreover, we believe that there would be some off-setting savings to the Medicare program by offering such coverage.

In a soon-to-be released study performed by the Department of Pharmacy Practice of the University of South Carolina, the authors found that, after the State of New Jersey implemented its Pharmaceutical Assistance to the Aged program (PAA), Medicare recipients had, on average, \$238.50 less in in-patient hospital reimbursement costs than a comparable group had in Pennsylvania where no program was offered. The study also showed that the length of stay in the hospital could be reduced by offering a prescription drug program. One of the study's conclusions was that "it appears that savings in reduced hospital stays are greater than or equal to the expenditures for prescription reimbursements plus the program's administration costs."

The New Jersey program requires a \$2.00 co-payment and links reimbursement to the Maximum Allowable Cost system (MAC) under Medicaid. We would suggest a benefit for older people that would require a \$1.00 co-pay and a \$200 deductible. The cost of such a program would be between \$1.6 billion and \$2 billion--about the same amount that would be raised through the coverage for state and local employees under Medicare.

Mr. Chairman, over the past 20 years, 136 bills have been introduced in Congress to cover prescription drugs and still no action has been taken. As a result, although at least nine states have enacted plans, older people in 41 states still have no assistance. Our senior citizens have been calling for prescription drug coverage long and loud over this period of time and I hope you will act to include such a benefit in your legislation.

The lower catastrophic protection cap, such as the one proposed in your legislation, Mr. Chairman, also helps us achieve the goal of increased coverage for out-of-pocket costs for the rest of the elderly population. NCSC commends your action in this area and your recognition of the burden that a \$2,000 cap would place on many beneficiaries. We would recommend that excess physician charges and prescription drug costs also be included to reach the cap. By not including these high-cost items, the cap would ignore a very significant portion of the elderly's health care costs.

As always, it's a lot easier to talk about what benefits should be provided under a public health care program than it is to determine who should pay for the added benefits. But, in this case, I think the answer is a fairly simple one--the burden should be shared. It is vital to keep in mind, as we discuss health policy and its effect on the deficit, that, since 1980, domestic programs serving the poor and the elderly have sustained deep cuts, even as the deficit has grown. As a result, many of our most vulnerable citizens have suffered increased costs while receiving less than at any time in recent history. The Medicare program's cuts already adopted will cost Medicare beneficiaries \$14 billion over the next five years.

Clearly, the elderly did not cause our current budget deficit. The Congressional Budget Office (CBO) recently found that, if the budget and tax policies that were in effect when the Reagan Administration took office had been continued, rather than changed, the Federal deficit in FY 1985 would have been \$80 billion (about the same as in 1981) rather than the \$212 billion level at which the deficit now stands. The changes in defense and tax policy, along with the increase in interest payments on the national debt, caused by these policies, added \$167 billion to the Federal deficit in

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1985, while domestic cuts--including reductions in Social Security, Medicare and Medicaid--reduced the deficit by \$38 billion. The net result was an increase in the deficit of about \$130 billion.

Let's keep in mind, then, that the elderly have done more than their fair share in being fiscally responsible and helping to reduce the Federal deficit. They have taken the cuts on the chin and in their wallets for seven years now and have asked for little in return.

There are, however, very real savings that can and should be found through the providers of health care in our country and, in fairness, savings from these cuts should be targeted to pay, at least in part, for any Medicare benefit expansion. In a very real sense, more than protection for Medicare beneficiaries from catastrophic health care costs, the Administration's plan offers bad debt protection for Medicare participating hospitals. After all, while all Medicare beneficiaries, under the President's plan, would contribute to allow three percent of seniors to gain some additional coverage for costs that hospitals might have ended up having to swallow, their payments would really provide financial protection for every Medicare hospital to ensure that the Federal government would cover these otherwise bad debts. And Medicare beneficiaries would pay for this insurance for hospitals at a time when hospitals are achieving 15 percent profits yearly under the Medicare prospective payment system, as was brought up in your hearing last week.

Consider the irony, Mr. Chairman. Senior citizens are being discharged from hospitals sooner and sicker and with less care waiting for them after the hospitals under PPS, while hospitals are enjoying fairly substantial profits under the same system that reduces care to patients. Then, these same patients would pay for additional financial protection to guard hospitals against unpaid debts.

The NCSC urges the Committee to consider the possibility of rebasing the DRGs to factor in more current cost and efficiency data and using the resulting savings, which the CBO estimates at \$4.4 billion in the first year, to help finance new benefits for the elderly. Hospitals, under PPS, are still being paid based on 1981 cost data, even though significant cost and efficiency savings have resulted since implementation of PPS. In addition, some services formerly provided during an in-patient stay, and included in the 1981 rates, are now provided in out-patient settings, or SNFs, where they are separately reimbursed on a reasonable cost basis. Lower, more accurate reimbursement rates would avoid what is, in effect, double payment for these services.

Nineteen eighty-four data is currently available on which DRG payment rates can be based. We firmly believe such action is very warranted and very fair, and that the resulting savings should be plowed back into the Medicare program.

Physicians should also be included in the finance design. Inclusion of hospital-based physicians' services in hospital PPS payments would raise \$70 million in FY 1988, \$170 million in FY 1989, and \$240 million in FY 1990, for an impressive three-year total of \$480 million.

However, NCSC does recognize that the elderly should participate, to some degree, in financing any kind of comprehensive benefit expansion. Although we do not support the taxation of entitlements, we applaud your recognition of the need for financing the program without overburdening the poor. NCSC shares that same commitment and would like to work with you in exploring other ways to progressively finance an enhanced benefit package. One of the very real problems we see with an actuarial value tax is the precedent it sets for taxing other entitlement programs and the possibility of counting such "income" for determining eligibility in low-income programs such as food stamps and low-income energy assistance.

The current Administration's proposal, with its reliance on a flat premium for all beneficiaries, runs the very real risk of increasing the burden on all beneficiaries in order to better

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protect the assets of only a small number of wealthier senior citizens. The additional premium, plus the Administration's high cap, would place a much greater proportional burden on low and middle-income Medicare beneficiaries. By contrast, the premium plus the cap would hardly make a dent in the assets of a few seniors and they would be protected from any further diminution of their assets after that. For these reasons, a progressive approach to beneficiary participation, with special allowances for the poor and the near poor, is vital to providing catastrophic protection for all elderly.

If premium financing is considered, we would urge that the Committee also consider some type of refundable tax credit to offset these costs for low and lower income older people.

In addition, NCSC advocates the inclusion of state and local employees under the Medicare program. Since the majority of these citizens eventually rely on the benefits and protections provided by the Medicare program, we believe it is entirely fair that they also be required to take part in the financing of the program. Revenues generated by this proposal should, logically, be used to at least partially finance the Medicare benefit improvement under a catastrophic provision.

In conclusion, let me just make mention of a very important public service of which the elderly are sorely in need.

A separate, serious problem facing the elderly, that we all have a grave responsibility to address, is the issue of breaking the news to the elderly of America that the public programs they've relied on, and that they may rely on in the future, do not cover long-term care. I am very concerned, Mr. Chairman, that the public at large, but seniors especially, are being given a very false sense of security in thinking that the Administration's catastrophic illness plan will provide for the costs of long-term care.

Already, a large portion of the Medicare population believes the Medicare program provides long-term coverage--a belief they've been allowed to keep for far too long. Now, just as they're beginning to hear that this may not be the case, the Administration is holding out a new plan that, in the words of the President, will "give Americans that last full measure of security."

The greatest financial fear of many older Americans is the spectre of nursing home care and the last full measure of security they can be given is protection from the costs of long-term care. The President's comments, I greatly fear, will only cause seniors to shift from one false hope of relying on the Medicare program to answer these needs to another of relying on the catastrophic plan that the Administration has proposed.

I think it's very important that we go forward with a Medicare improvement plan, but I feel very strongly that it is incumbent upon all of us involved in shaping this public policy that we are very clear in describing just what the plan will--and won't--do for prospective beneficiaries. It would, in our opinion, be absolutely unconscionable if we were misleading on this information. If the plan would not include long-term care benefits, that message needs to get across. NCSC will do its part in trying to ensure that Medicare beneficiaries and their families have factual, full information on which to base their decisions on planning for future needs. Medicare beneficiaries must not be lulled into a pleasant, but erroneous, belief that their long-term care needs will be met by paying \$4.92 a month more in Medicare premiums.

Finally, we must not fail to recognize the fact that the plans under discussion deal only with the elderly population. Even as advocates for the elderly, we recognize and sympathize with the plight of 37 million younger Americans who have no health insurance at all. We also know that catastrophes affect people of all ages and that something must be done to help these people as well. Mandating employers to provide health insurance is one step. But, we should also consider requiring states to provide Medicaid coverage to all those living below the poverty line. A major step

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was taken in this direction in the last Congress and we must continue to press for such a Medicaid expansion.

Thank you, again, Mr. Chairman, for the opportunity to testify and present our views on the need for catastrophic health care protection this morning. As always, your leadership on this and other health issues remains invaluable to the senior citizens of this nation. We applaud your efforts in this area and your interest in helping to solve the very difficult and complex problems of catastrophic care for this nation's 30 million Medicare beneficiaries. We hope our suggestions have been helpful and we sincerely hope you will continue to call on us in the future as we look for compassionate, reasonable solutions to the problems facing the elderly.

Chairman STARK. Mr. Pollack.

**STATEMENT OF RONALD F. POLLACK, EXECUTIVE DIRECTOR,
VILLERS ADVOCACY ASSOCIATES**

Mr. POLLACK. Thank you, Mr. Chairman. I want to thank you very much for inviting me to testify, and thank you also for the fine leadership you are providing on this issue. You and your very able staff should be commended on the work that you are doing on this issue.

The Villers Advocacy Associates is a nonprofit group concerned primarily with low and moderate income older people, so my testimony today will focus for most of its part on how the catastrophic proposal touches on their lives or fails to touch on their lives.

I have four essential points to make in the testimony. First point. The proposed catastrophic health care package offered by the administration is exceedingly small. We know the litany of the different areas that are wholly uncovered: the 37 million who are not going to be served, long-term care, and the various uncovered services under Medicare.

We think that the catastrophic health care debate presents a wonderful window of opportunity and, in fact, it is being heralded by many people as our greatest opportunity to make significant health care change. And so therefore it is important that we not miss this opportunity and achieve too little.

The administration claims that its proposal would benefit approximately 1.4 million people, and our estimates indicate that this is a gross exaggeration. Secretary Bowen says that 1.4 million seniors have hospital and physician expenses in excess of \$2,000, but that 1.4 million figure should not be confused as the number of people who will be benefited by their package.

The people who will be benefited really are lowered by a significant amount due to two factors. First, the figure includes the excess charges that physicians impose upon Medicare's allowable rate, and those excessive charges do not count in the catastrophic computation.

But perhaps more importantly, there are 550,000 seniors out of the 1.4 million, who would deplete all of their assets if they had spent \$2,000 on health care costs, and therefore they will not be benefited by this catastrophic health care package.

If you reduce just that 550,000 from the Secretary's estimate, at best there are 850,000 people who would be helped; 3 percent of the elderly, or approximately one-third of 1 percent of the entire population.

Now I think that a good number of seniors and the American public in general will be very confused by this catastrophic debate, and the questions I hear, if I may paraphrase them, that most elderly are going to ask: Why does \$2,001 of hospital costs constitute a catastrophe but \$2,001 in prescription drugs or other uncovered services do not constitute a catastrophe? Why is it that 2 months in a hospital constitutes a catastrophe, but 10 months in a nursing home does not constitute a catastrophe? Why is a health care expense of \$2,000 for a millionaire elder a catastrophe, and \$1,500 in

health care costs for a low income elder who depletes all of his or her savings not a catastrophe? That leads me to my second point.

The second point is that the administration's package is, I believe, inequitable in terms of its distribution of benefits and costs. As I indicated, very little assistance will be provided to the elderly of modest means. Their resources essentially will be entirely depleted before the catastrophic cap comes into play.

Let's look at some of the statistics about the lower income elderly. Forty-two percent of the elderly have incomes below \$10,000. If they experience \$2,000 in hospital and physician costs, they would be spending at least 20 percent of their income on hospital and physician costs, and that, of course, does not include the various services that are uncovered by Medicare, such as prescription drugs and the various other services that are uncovered.

So easily health care expenses could amount to 30 to 40 to 50 percent of their income. The \$2,000 figure, in contrast, for a more affluent elder is merely an inconvenience. What the administration then winds up doing is it adds insult to injury. Even though the benefits disproportionately will go to higher income seniors, the administration proposes to finance the package in such a way that lower and moderate and middle income seniors will pay the exact same thing for this coverage even though the wealthier seniors are going to get the disproportionate benefit of it.

Let me illustrate that with one set of statistics that I haven't heard this morning. We worked with Judy Feder, who you heard from earlier this morning, to try to take a look at what is the cost-benefit ratio of the administration's plan for lower income seniors versus the cost-benefit ratio for high income seniors. In other words, what do low income elders get for the premium that the administration would impose in terms of benefits.

If you look at the cost-benefit ratio for an elder whose income is under \$5,000, under the administration's plan they will get 2 cents out of the dollar in coverage. For elders with incomes in excess of \$20,000, they would receive \$1.66. And the reason that it is such a low return from the dollar is because, for the overwhelming majority of seniors who are of low income, they would not receive a benefit from the catastrophic package. They may be already eligible for Medicaid or they may have already depleted their entire savings as a result of the \$2,000 expenditure. So for them, they are not going to receive a significant return from the dollar as higher income seniors would receive.

Now how can we improve the package? The chairman, I thought, aptly indicated, and it was referred to before, that the perfect should not be the enemy of the good, and our hope is that the good ultimately would not be the enemy of the better. And in that spirit I would like to propose four different changes that we hope would be considered.

The first change would be to provide more Medicaid protection for the economically vulnerable. I recognize that this would require some joint jurisdiction with the Energy and Commerce Committee, but it is important to note, Mr. Chairman, that your package will save significant Medicaid dollars and those Medicaid dollars can well be used to finance improvement in the Medicaid package.

Now what are the improvements that can be made? We urge that there be a mandate that Medicare's cost sharing be covered through Medicaid for all the elderly and the disabled whose incomes fall below the poverty line. Currently about 64 percent of the elderly whose incomes fall below the poverty line, about \$5,000 of income for a person living alone, do not receive Medicaid coverage at all. Almost two out of three seniors below the narrow poverty line are not receiving Medicaid.

If we took the savings in the Stark-Gradison bill, which are very significant, and plowed them into purchasing Medicare cost sharing, we not only would be able to pay for it entirely, actually, we would still yield a bit of a surplus.

Chairman STARK. If I could interrupt for a moment, I am led to believe that the Medicaid savings that this bill would generate would be enough to allow all of the States to provide Medicaid benefits to everybody below the poverty line, about \$7,500 or \$10,000.

Mr. POLLACK. It would certainly pay for the buy-in. That is right.

Chairman STARK. But as you so aptly put it, that is not completely within our jurisdiction.

Mr. POLLACK. No. But you have done a real service to the Energy and Commerce Committee, which would now have——

Chairman STARK. I am waiting for Mr. Dingell to recognize that service with the proper public recognition. [Laughter.]

I am sorry. Go ahead.

Mr. POLLACK. In terms of the dollar figures, as best as we can calculate it, in fiscal year 1988 the savings on the Medicare side from your package, Mr. Chairman, would be \$174 million, and the buy-in that I am talking about would cost \$130 million.

In fiscal year 1989, the savings from your package would yield \$296 million, and the buy-in that I am talking about would cost \$153 million. So it is clear that you could still provide this protection for the poor, and you would still yield a surplus.

I would also like to suggest where the rest of that surplus should go. My recommendation focuses on an issue that has been raised by several witnesses today, namely the issue of spousal impoverishment. I understand full well that this committee may not want to consider at this moment undertaking a comprehensive review of long-term care, but that should not deter us from trying to make at least an important incremental improvement. And perhaps the incremental improvement that should be made would be to try to make sure that the community spouse, the spouse who stays in the community when her husband goes to a nursing home, that she is not brought to total destitution as a result of her husband going into the nursing home.

The New York Times had a wonderful article about this about a year ago. Many of you may have seen it. In that article The New York Times wrote about a couple who had been married, happily married for decades, and they had been essentially a middle-class family——

Chairman STARK. Mr. Pollack, I am the worst offender, but in the interest of the panel here, we are under an unusual time constraint today. We need to vacate this room at exactly 12:30. I think perhaps some of the members might like to question you and the

other panelists in that remaining time, and you would be able to elaborate some of these points during that interrogation.

If the members would like to and will yield back their time. But I would like to recognize the members at this time.

Mr. PICKLE. Well, Mr. Pollack, you were going to make four recommendations. You have made one. Would you like to mention the other three?

Mr. POLLACK. Well, the second one would be to deal with spousal impoverishment so that the spouse who remains in the community is not forced to her knees as a result of the need for care of her spouse.

The next area is one that several witnesses have talked about, and that is prescription drug coverage. I am delighted to hear that the chairman is going to be offering a bill on that issue. I can say that I think that if that occurs there would be strong and enthusiastic support to provide prescription drug coverage.

Did I misunderstand the chairman?

Chairman STARK. Mr. Donnelly just said he is going to cosponsor it.

Mr. POLLACK. Well, we may have brokered a deal here then today. [Laughter.]

I think that if prescription drug coverage were included in this package, I think that you would receive tremendous support from the senior population. And I must say there has been a real movement around the country. Eight States have already adopted such provisions at the urging of lower income seniors, and that would bring out a lot of enthusiasm in people.

And finally, the last one, Mr. Pickle, would be to strengthen our transitional care after the release of somebody from a hospital. We know that a good number of people are being released from hospitals sicker and quicker, and we know that the administration has clamped down on the transitional services that they need, particularly in the home. And it is our hope that the care that they receive after hospitalization can be strengthened to its original intent by Congress.

[The prepared statement follows:]

CATASTROPHIC HEALTH CARE

Statement by

RONALD F. POLLACK
Executive Director
VILLERS ADVOCACY ASSOCIATES

before the

SUBCOMMITTEE ON HEALTH

of the

HOUSE COMMITTEE ON WAYS AND MEANS

Washington, D.C.

Wednesday, March 4, 1987

Mr. Chairman and members of the Subcommittee, thank you for this chance to testify. Your quick attention to the problem of catastrophic health care expenses, particularly among the elderly, deserves special thanks from everyone concerned about it.

Although my comments today will focus on the elderly and disabled, and how their specific health care burdens can be eased, let me emphasize that older people and those working on their behalf are deeply concerned about the lack of health care access among the 37 million Americans with no health coverage at all -- the unemployed, workers with no coverage, the poor who don't qualify for Medicaid, and their families. In particular, Mr. Chairman, your work to promote state-level action on this enormous problem through mandatory risk pools is commendable. Elderly advocates have supported those actions, and will continue to do so.

Since our organization's major concern is for low- and moderate-income older people, the bulk of my testimony will be concerned with the programs aimed at providing health care coverage for them through Medicare and Medicaid.

When President Lyndon Johnson signed Medicare into law a generation ago, he hailed the dawn of a new era: "No longer," he said, "will illness crush and destroy the savings that [older Americans] have so carefully put away over a lifetime, so that they might enjoy dignity in their later years."

Medicare has been a blessing to millions of older persons. But the lofty dream expressed by President Johnson has only partly come true, and, for low-income seniors, health care costs continue to be a nightmare.

GAPS IN MEDICARE COVERAGE

Medicare was enacted because, America concluded, our older citizens were spending too much on health care. Yet more than 21 years later, older Americans spend as much out of pocket on health care -- about 15%, on average -- as they did before Medicare was enacted. I know, Mr. Chairman, that you have heard that fact before, but I believe it bears repeating. Those out-of-pocket expenditures among the elderly are three times those for younger Americans: \$1,055 per older person in 1984, versus just \$310 out of pocket for younger persons, and these figures do not include the costs of long term care.

Hospital Coverage

Although, in general, Medicare coverage for hospital stays is good, holes remain in the protection. The \$520 deductible -- up 155% in just the last six years -- remains a significant burden, especially for the 20% of beneficiaries who have no supplemental, or "Medigap," insurance. And those few who experience hospital stays greater than 60 days -- less than 200,000 out of 28 million elderly Medicare beneficiaries -- risk being required to pay thousands of dollars out of pocket.

Physician Coverage

Part B of Medicare, which covers physicians' services, is woefully inadequate. Before Medicare will pay a dollar toward these bills, an elderly beneficiary must pay a monthly premium that totals \$215 a year, and meet an annual deductible of \$75. Only then will Medicare pay 80% -- of its approved charge, not of the actual bill. Doctors are free to charge more, and seven out of ten doctors do just that for some of their patients. So the true copayment facing many patients is not 20% but 30, 40, even 50%.

Uncovered Services

Drugs. Medicare will not pay for prescription drugs, though older Americans depend on them to a far greater extent than others in the population. The millions of elders suffering from such chronic conditions as high blood pressure, diabetes, various heart conditions and some types of cancer, depend on medication to help control those problems. Those costs come almost exclusively out of pocket. Some 6.7 million older Americans -- 24% of all seniors -- are taking three or more prescription

drugs. And from January 1980 through 1986, prescription drug costs rose about 80% -- 2 1/2 times faster than consumer prices in general.

Prevention. With very limited exceptions, Medicare will pay for nothing that aims to prevent illness or disease, or that maintain health, like physical examinations, or health screening, or preventive vaccines.

Other Services. Seniors in need of foot or eye care, or dental attention, or in need of hearing aids, eyeglasses or dentures, quickly discover that Medicare virtually ignores these needs.

Transitional Care. As Medicare's prospective payment system has pushed more elders out of the hospital "quicker and sicker" and in need of more intensive services, beneficiaries increasingly find themselves in a "no care zone." This problem has been terribly exacerbated by the current Administration's (we believe unlawful) efforts to reduce the amount of home care available after hospital stays.

Long term care. Although persons of all ages develop chronic conditions that limit their ability to function in the community, the chances of developing such a condition increase dramatically with age. An official survey in 1982 found that 18% of those over 65 had limitations in such basic activities as bathing, dressing, eating, cooking or cleaning. That's in addition to the million and a half older people, for whom these physical or mental disabilities required care in a nursing home. Medicare covers only the tiniest fraction of the cost of providing this care, whether in institutions or in the community.

There is one major governmental help in paying for long term care: the Medicaid program. Unfortunately, in most states, Medicaid pays for only institutional care, that is, nursing homes. Further, eligibility and program rules almost force a

person -- and his or her spouse -- to become impoverished in order to get Medicaid assistance.

ADMINISTRATION RESPONSE FALLS SHORT

On February 12, the President announced White House support for a plan to partially restructure Medicare. In his statement, the President captured the essence of the problems needing attention:

A catastrophic illness can be a short-term condition requiring intensive acute care services or a lingering illness requiring many years of care. It can affect anyone The single common denominator is financial. It can require personal sacrifices that haunt families for the rest of their lives.

HHS Secretary Bowen deserves credit for pushing this issue to the fore in the Administration, and the President deserves credit for taking the Secretary's advice, calling attention to this crushing problem, and helping to define it.

But as to the proposal put forth by the Administration to remedy the problem, I regret that I must be much less positive. The White House plan leaves so many holes in catastrophic health protection -- even for seniors -- that many of us have begun describing it, not as an "umbrella," but as an uNbrella, exposing millions of older Americans to torrents of devastating health care bills.

- There is no relief for the millions of older Americans in need of vision care, dental care, foot care, or hearing aids and other devices needed to improve these areas of functioning.
- There is no help for older Americans from the \$8 billion they spend each year on prescription drugs.
- There is no movement to reduce later, greater health expense from acute illness -- and the suffering it represents -- by providing preventive or health maintenance services.
- There is only the slightest gesture toward restraining the billions of dollars spent on doctor bills. For every dollar older Americans spend out-of-pocket on hospital cost, they spend \$4 on physicians.
- There is no recognition in the plan of the President's definition of the problem -- that of financial devastation. The White House plan uses the same flat, narrowly defined and very high amount -- \$2,000 in spending for specific, Medicare-approved expenses to trigger catastrophic protection for all, despite the considerable variation in burden it represents for well-off seniors, on the one hand, and moderate- and low-income seniors on the other.
- Most fatally, there is no mention of the most catastrophic health care expense for the elderly, that of long-term care. Among those who actually spend \$2,000 out-of-pocket in a year, more than 80% of the total goes to pay for nursing homes. For every dollar they spend on hospitals, America's elderly spend \$8 out of pocket on long term care.

Even among the people claimed to be helped by the White House plan, there is considerable overstatement. The assertion is that 1.4 million persons -- about five percent of 28 million elderly Medicare beneficiaries -- will benefit from the plan. That seems to overstate the plan's impact in two important ways.

First, the November 1986 report to the President on the subject concluded that 3.1% of the elderly, or about 800,000 persons, had expenses over \$2,000 in 1983. If these new calculations were arrived at the same way, and there is no indication they weren't, fully 22% of those bills came from the excess fees of physicians who did not accept assignment. Many of those 1.4 million -- how many, we could not determine -- would be pushed over the \$2,000 cap only if excess physician charges, which the White House plan does not count toward the cap, were included.

Second, the Urban Institute has calculated, based on the March 1984 Current Population Survey data, that 43% of all elderly had liquid assets of less than \$2,000. Even after adjusting to account for those on Medicaid, one must conclude that at least 39% of the 1.4 million claimed beneficiaries of the White House plan -- almost 550,000 persons -- would have their life savings completely wiped out before ever reaching the trigger for protection.

Another way to look at this issue is by returning to the definition of "catastrophe" for those purposes. Surely, someone spending 20% of family income on health care has suffered a catastrophe. Under current law, according to Dr. Judith Feder, from whom the Subcommittee has already heard today, about 18.2% of older people with incomes below \$10,000 spend more than one-fifth of their total income for health care. How does the White House plan help them? Virtually not at all. Under it, 18.2% of these economically vulnerable people -- unchanged from current law -- would still spend one dollar in five for health care.

Finally, the financing suggested for the White House plan makes the package, taken as a whole, look like "Robin Hood in reverse."

Clearly, as the discussion about assets highlights, those who will benefit from the White House plan will be, disproportionately, those with substantial assets to protect. At the very least, they will find their Medigap premiums reduced to reflect greater governmental protection of those assets.

Yet the financing mechanism for the White House plan is a flat, \$5 a month premium, identical for rich and moderate income and poor alike.

It is as if the owners of a \$20,000 run down hovel were to be charged the same fire insurance premium to protect their home as were the owners of a \$2 million mansion.

The result, according to Dr. Feder, is that an elder with income under \$5,000 would get back an average of just 2 cents for each premium dollar paid, while those with incomes over \$20,000 would receive \$1.66 in benefits for each premium dollar.

Surely Congress will not allow this regressive redistribution.

STARK-GRADISON: A STEP FORWARD

Fortunately, Congress seems to recognize that it can and should go farther.

The improvements included in the bills introduced by you, Mr. Chairman, and other Subcommittee and Committee members, are important steps in that direction.

- o Lowering the overall cap to about \$1,600 recognizes how ludicrous the \$2,000 limit really is.

- o Tying future increase in the capped amounts to likely future increases in Social Security benefits, rather than to still-spiralling medical prices, is especially important.
- o Reducing and restructuring today's skilled nursing copayment makes that elusive benefit somewhat more valuable for those fortunate enough to get it.

Most importantly, your recognition of the inherent regressivity of a flat premium approach to financing deserves high praise. The income tax system is inherently fairer, more efficient, and more rationally related to a package of benefits that favors disproportionately those with higher incomes and assets.

RECOMMENDATIONS FOR FURTHER IMPROVEMENTS

But from the standpoint of moderate- and low-income older people, we would urge you to take further steps to plug some of the numerous gaps you have heard identified today. Here are a few suggestions:

1. Protect the economically vulnerable. At the very least, better protection is needed for poor and near-poor elders. States should be mandated to allow elders below the poverty line to have the Medicare out-of-pocket payments paid for through Medicaid. A buy-in mechanism could be established for those below twice the poverty line.
2. Strengthen transitional care. The skilled nursing benefit has been illusory, deceptive and inordinately expensive for many who do receive it. Home health, which should be of greater and greater importance as hospital stays shorten under prospective payment, disappears over the horizon as the Administration squeezes the intermediaries to control costs by any means. Congress should reassert its intent that these and other transitional services should be routinely available when the patient's doctor says they are needed.
3. Add needed services. The case for providing prescription drugs under Medicare is strong. Eight states already recognize this need, and have not experienced unmanageable expense. Modest preventive services could identify potential major health problems at earlier, more treatable, stages. Vision, eye, dental care, and medical appliances should be added.
4. Other Medicaid expansions. Perhaps no greater catastrophe occurs than that suffered by one spouse when the other must enter a nursing home. I understand the jurisdictional problem here, but I urge the Subcommittee to work with and encourage their Commerce Committee colleagues to find answers now for this "spousal impoverishment" absurdity.
5. Lower, broaden the cap. Even the lowered cap envisioned in H.R. 1280 and H.R. 1281 will expose millions of elderly to catastrophic expenses. Dr. Feder estimates that a \$1,500 cap, even if including prescription drug costs, would reduce the proportion of the economically vulnerable spending 20% of their income on health care only from 18.2% to 17.8%. A much lower cap, and one that includes more expenses not paid for by Medicare, should be the goal. Even more desirable would be a comprehensive cap tied to income, since, as the President noted, what is being discussed is financial catastrophe, a relative concept.

FINANCING IMPROVEMENTS

If the Subcommittee acted favorably on all of these recommendations, the price tag would be substantial. But we believe the climate is right for pursuing this agenda, and the resources to pay for them are within grasp. A number of financing possibilities exist, among which are the following:

First, retain the tax-system-related mechanism for financing, such as the one suggested by the Stark-Gradison bill. Another might be simply a tax surcharge, even more progressive, and less fraught with the philosophical problems of counting in-kind benefits as income.

Second, make state and local public employees begin paying into Medicare, which virtually all of them will benefit from when they retire.

Third, look closely at tobacco tax increases, and denial of deductions for tobacco advertising, in recognition of the substantial Medicare expenditures caused by smoking.

Fourth, explore ways to adjust payments to hospitals, in view of this panel's recent hearings on profit margins under prospective payment.

CONCLUSION

Mr. Chairman, you, your Ranking Minority Member and other Subcommittee colleagues deserve much gratitude for spotlighting the importance of patching the catastrophic expense holes in our current health system, for elders and all Americans. Your legislation moves the debate in the right direction.

We urge you to strengthen that legislation -- and thus, the grass-roots support that can be generated for it -- by broadening its protection in the ways suggested. That will allow the best chance of retaining and building on your bold and right headed financing plan.

We look forward to working with you in shaping and supporting a responsible and compassionate proposal.

To do less would be the worst catastrophe of all.

Chairman STARK. Mr. Levin?

Mr. LEVIN. Thank you, Mr. Chairman.

I didn't have a chance to read your testimony before, so I just know what I heard. Not to put words in your testimony, but the flavor seems to be that if we could take the Stark-Gradison bill and improve on it somewhat, but not make a major dent in long-term care this time, the flavor of your testimony is that while you wouldn't be totally happy, you would consider it a significant step forward.

Is that accurate? Again, I want to hear your characterization, not mine.

Mr. HUTTON. Well, I support entirely the approach which is—pretty near entirely—the approach that is taken by Mr. Bob Ball this morning. I thought that he got over the concept that it really isn't a catastrophic insurance program that we are worried about. What we are really worried about is that we have had Medicare for more than 20 years and we haven't improved it any way since, and it is high time.

People are dying out there because of the lack of attention by the Congress over 20 years, and it is time, as that play said, "Somebody is dying out there and attention must be paid." Now that is the kind of thing that I am thinking about.

Improve Medicare the best way that you can do. Now I think you can do that if you put your hearts to it and your minds to it, and if you get a sense of commitment. I believe it was said by Claude Pepper this morning, and I think it was shared by the chairman, that even Shakespeare said it a long time before: There is a time which when taken at the flood leads on to fortune and omitted all our lives are bound in shallows.

Chairman STARK. I was there. [Laughter.]

Mr. HUTTON. I wouldn't be surprised.

Mr. LEVIN. You were there when the Senator said it or when Shakespeare wrote it? [Laughter.]

Mr. DENNING. I really think what you are looking for here is balance: a product that serves the people balanced by appropriate financing mechanisms. We know we have the deficit and we are not recommending something that increases the deficit; the catastrophic plan can and should be budget neutral. But people are looking for a product that will truly give them relief in their troubled hours. We are presenting a proposal that will provide this kind of protection, be budget neutral, and draw upon appropriate financing mechanisms.

We feel that the administration and Stark-Gradison plans do not go that far. They open the door and the window for debate—a very important step.

Chairman STARK. If the gentleman would yield, I would like you, though, to focus on his question which I think, at least for me is saying that we are going to try and get all we can, and the benefits are fairly easy to describe.

The question is, in the opinion of the witnesses, if we don't go all the way, are we going in the right direction? Because what we may establish this year can be, perhaps, expanded next year or the year after.

If pharmaceuticals cost \$8 billion and we have an extra \$2 billion, maybe we will just cover 25 percent of the pharmaceuticals. Or maybe we ought cover all pharmaceuticals for the lowest 25 percent of the income group. That is not too difficult to sort out. The question is in the financing or in the allocation of the benefits, or as between Medicaid and between income relating benefits. Are we heading in the right direction, or what directions would you all recommend because you are representing the beneficiaries. We have had a lot of testimony from experts, and we have experts on our staff. Now the question is what do the folks that you represent want most, or what is the best way to satisfy most of them?

I am sorry to step on your lines there.

Mr. LEVIN. No, no.

Mr. HUTTON. Mr. Chairman, I support the concept of a drug issue. I don't think that perhaps the Members of Congress realize the kind of pressure that the associations get on the issue of providing the right kind of medicines at the right kind of price.

Now I know there is a lot in those two statements. The right kind of price, because the cost of prescription drugs has gone up and up and up, and they can't afford it. So it is difficult, but I think that that is very much on their minds. They really can't afford it any more.

Mr. POLLACK. I don't think there is any question, if we could do something on prescription drugs, I think that there would be significant enthusiasm on the part of the senior population, and I think that should be a very high priority.

But getting back to your question, Congressman Levin, I think that even if we don't do a comprehensive long-term care package, we can at least alleviate perhaps the worst manifestations of the problem, and that is the impoverishment of the spouse who remains in the community. That is not an expensive thing to do. As best we understand, CBO estimates that that would cost about \$150 million.

Now I think that within the parameters of the package that is being developed, one could insert that into the package, and I don't think it would be that difficult to find a way to finance it. Indeed, the Medicaid savings that are generated by the Stark-Gradison proposal, as I indicated, yields significantly more money than the Medicaid proposals I mentioned before, and the amount of money that is a difference in the third year would pay for that spousal impoverishment element.

Mr. LEVIN. Thank you.

Chairman STARK. Mr. Donnelly?

Mr. DONNELLY. I want to go back to the issue of means testing, taking into account people's ability to pay. If, in fact, we create this new program, protection from catastrophic medical expenses—how far we can go we don't know—would you agree with me that it is necessary to put in some sort of means test into this expansion of the Medicare program?

Mr. POLLACK. Mr. Donnelly, I am not sure I would use the same language that you are using. But let's talk about the concept. What we have in terms of catastrophic health care is really asset protection, and let's look at it as assets protection. That is really the heart of the catastrophic plan.

Now if you had \$2 million of assets you wanted to protect in a home—let's say you had a mansion. Let's say I had a hovel. And your mansion cost you \$2 million and my hovel cost me \$20,000, and I was trying to protect that asset. Clearly, if we were paying the exact same premium, one of us would be deeply concerned about that. Because we wouldn't quite be getting equity for our respective purchases.

And that is my concern with the Administration's financing proposal. The administration's financing proposal is terribly inequitable. It charges everybody the same thing, even though it protects much larger assets for higher income folks; and for lower income people, whose assets will be entirely depleted before the \$2,000 cap comes into play, they are being asked to pay the same amount for much less protection.

Therefore, I am very pleased to see that Mr. Stark and Mr. Gradison have moved the debate in a very progressive direction. I do not have any concern about using the income tax structure for financing these benefits. It is a progressive way to do it. I wouldn't call it means testing. I don't believe it is means testing, but it is using a more equitable approach. It is essentially using the income tax mechanism, and I think that the chairman and the ranking minority member are moving in the right way.

I think there are other ways to do it that lead in the same direction, but I think that it is movement in the right direction.

Mr. DONNELLY. Gentlemen?

Mr. HUTTON. We don't support means testing, but we do support some form of progressive taxation. I believe——

Mr. DONNELLY. Well, we finished that off last year.

Mr. HUTTON. I hope you did. [Laughter.]

Mr. DONNELLY. Go ahead.

Mr. HUTTON. As I say, I believe that——

Mr. DONNELLY. But the reality of the situation is there is not going to be, at least in the 100th Congress, any bringing back of progressivity into the Tax Code. So the question is how are we going to pay for this new expansion of Medicare? Ought it be some sort of asset protection or means testing in there? That is the question.

Mr. HUTTON. Well, we believe, as I said, that the older people themselves can pay a small part. Health care providers should pay a part. We should, as I believe, broaden the Medicare coverage to include the State and local employees and that will help Medicare.

But there are other progressive ideas. Estate taxation. The right kind of estate taxation I think is important. And perhaps a modified exchange of capital.

Mr. DONNELLY. Estate tax, you are talking about reducing the unified credit?

Mr. HUTTON. Yes, I am. And I am also talking about modifying, for example, the exclusion of capital gains on the sale of a house. At the moment it is \$150,000. A lot of people would crave for \$150,000 house, but they haven't got it. But they don't need taxation freedom of \$150,000. Perhaps that can be reduced to \$75,000.

Mr. DONNELLY. Keep going, it is adding up. [Laughter.]

Mr. Denning?

Mr. DENNING. Well, I am sure that you understand that our association doesn't support means testing, either. However, I think that our differences may be more semantic than substantive. The same discussion may mean one thing when we say it one way, but another when said in another way. And I think that you would find, if you were to check with older people, as we have, that they are willing to pay for a package that gives them true catastrophic protection.

That is the reason that Ron was making: the package needs to include acute care; protection against spousal impoverishment; prescription drugs and an expanded transitional benefit—addressing the things that are such a burden today. And if you look at our charts up there, it is very easy to see where the greatest need is.

So we want to see a catastrophic package developed. As for the financing, I would like to discuss options in the context of a benefit package—our members are willing to pay for a package they consider worthwhile.

Chairman STARK. Would the gentleman yield?

Mr. DONNELLY. Sure.

Chairman STARK. That is an interesting concept, Mr. Denning. I remember about a month or so ago, that we did just that, or I did, with your board. And sooner or later we are all going to have to fish or cut bait.

Now I am, believe me, as open to suggestions of financing as you can dream up. But you may have the luxury of having 24 million people vote for you every year because you run opposed. [Laughter.]

But with the AMA lurking in the wings, I don't have that kind of comfort in my position. I want the AARP to feel comfortable with our bill, and I want to see that we are going in the right direction.

But there are some other alternatives. Mr. Donnelly is going to talk about State and local taxing. There are estate taxes, where you lose—my children will oppose that immediately.

But the question is between perhaps the idea of the flat \$5 fee, or \$6 or \$7, and a combination of the two. I have no quarrel if you want to tax part of it—part of the benefits and have a premium for the other part.

Where does the AARP come out on this? You can't tell me that you are sitting there with those 24 million people and they are going to wait until 8 months from now. Because this is your chance. Speak up.

Mr. DENNING. We have discussed your bill, and it certainly is a wonderful step in the right direction. And the fact that we are debating here today is a real plus.

Chairman STARK. Excuse me. Which direction do you want to go?

Mr. DENNING. The question here is whether or not you have sufficient benefits tied up in your package to justify the radical change in financing. Now that is the question.

Chairman STARK. That was the question the AARP brought up last year and the year before. And if we wait for the AARP to make up their minds, we aren't ever going to have a bill. Honestly. Darn it, you guys have been good friends, but that is exactly what I heard last year. We will support this expansion but it isn't enough.

Now my mother used to tell me enough isn't enough. And I didn't believe her then and I don't believe you guys now. We have to get some progress or the public is going to say exactly what Mr. Ball said: We have never done anything.

The climate is right. I will tell you, when you get Mr. Gradison and me and Secretary Bowen and the President all together you had better reserve one of those puppies, my friend, because you are never going to get a chance for a breeding like that again. [Laughter.]

All I am saying is I think we are going to expand benefits. I am sure we are not going to expand them enough to satisfy everybody. I am sure that we are going to find a way to finance that because we are charged with revenue neutrality. Those are our only choices.

We will work with you to get all the benefits we can. Now which direction would you choose to have us go in financing?

Mr. DENNING. In my testimony I have suggested a tobacco tax—and he mentioned alcohol—as one financing source. Users of tobacco have higher health care costs, so we are suggesting that they should pay more for health care coverage. So we have suggested a tobacco tax—and now you frown. And I am from North Carolina, incidentally.

Chairman STARK. I understand. No. Listen. And I am from the wine country of America.

Mr. DENNING. You have talked about coverage of State and local employees under Medicare, and I think we are probably on pretty good common ground on that one.

Chairman STARK. All of those things I will stipulate to. And even over Mr. Donnelly's objection, but that isn't going to be enough.

Now to get where you want to go we will do the excise taxes. We will tax everybody that ought to be taxed, and we will do all of these things and we are short. Where do we pick up whatever we need, the last \$5, the last \$10, the last \$15 billion? All I am asking you, please, is to tell us, do we head down the road toward a flat premium or do we head toward some kind of progressive addition?

The easiest way is through the income tax. We could income relate if you want. The income tax is just easier. Now which way do we go, please?

Mr. DENNING. I think you have to recognize income relating does have some merits.

Chairman STARK. That is beautiful. Thank you. [Laughter.]

Mr. DENNING. Not means testing now. Not means testing.

Mr. DONNELLY. We have to leave, and it is my turn. I will yield in just one second.

Chairman STARK. Go ahead.

Mr. DONNELLY. The point that I am trying to get across is that I just don't believe looking long term down the road that we can afford to expand entitlement programs or create new entitlement programs without factoring in people's ability to pay. I think that, had we done that in the sixties when we created many of these programs, we would be in much better shape, and they would probably be more expansive in terms of their coverage than they are today. That is just the point that I am trying to make, and I yield to my friend from Michigan.

Mr. LEVIN. I just wanted to say one word, which doesn't express disagreement with the two of you. It was said earlier today that to means test is to turn Medicare into a welfare system. And I just hope that none of you will say that that won't be your organization's motto. Because whether you call it means testing or income relating, and there are differences, there is a relationship to income. We means test or income relate student loan programs, and we don't call that a welfare system.

Chairman STARK. Means test is an access issue. Everybody is going to have access. Income relating is how you pay. I agree that means testing should never be used to determine access. That is what brings fear to my heart and other's.

Mr. LEVIN. Exactly. But when some people talk about means tests, some of us are talking about income relating. And I hope when it is said in capsule form that a means test is to turn a program into a welfare system, you don't mean that any income relating does that. I think that most of us who deeply believe in the broad expansion of Medicare in a reasoned way do not believe that income relating the system turns it into a welfare system.

I think when we began income relating Social Security many of us said it was a package and used that as an excuse. But I think most of us were comfortable with income relating Social Security, and I defended it. I think that for people who are making \$75,000 a year to pay the same amount as people who are making \$10,000 or \$15,000 a year for this major benefit—catastrophic—I don't think that is fair, in simple terms.

Mr. DENNING. But you have got to explore these other alternatives before you ever get to the—

Mr. LEVIN. We have explored them. It is easy to talk about these other alternatives, but it isn't so easy when there is a veto promised.

Mr. DENNING. We have studied the proposal that our association has made to you, and it is pretty sound. Of course, we are also interested in knowing CBO's entitled to discussion with the assessment of our proposals where we don't already.

Mr. LEVIN. Just to finish, the chairman's point is that we may reach the point where we have to choose between expansion of Medicare with a way to income relate it, or maybe not at all. If you put yourself in the position of opposing any income relating, you probably leave your allies here—and they are not only on this side of the aisle—no room to move, or room to move only over your deep position.

Mr. POLLACK. I think you have heard from each of us that movement towards a progressive financing system would be highly desirable. There are some questions among us as to what would be the best way to do it.

Mr. LEVIN. It would be progressive tied into the Medicare system itself, not necessarily alcohol and excise taxes.

Thank you.

Chairman STARK. Thank you. Your help, and your organization's forbearance will help us tremendously. It is, after all, the people you represent that we are attempting to assist. And you are going to have to, like us, make some decisions. And when you have got 24 million people, you are talking about 80—none of us get 80 percent

of the vote. You have got it. You are not going to have unanimity among 24 million members of the AARP. You will be lucky to get a majority. So you are going to now have to accept the responsibility of leadership and help them make some choices.

Together we are going to have to choose one of these days and agree to go off in that direction and hope like hell we are right. And I hope in that direction you will all be with us and we will be working together to get the best system we can.

Thanks a lot.

Mr. DENNING. We will try to help you all we can.

Chairman STARK. The subcommittee stands adjourned.

[Whereupon, at 12:35 p.m., the subcommittee adjourned, to reconvene at 10 a.m., Tuesday, March 10, 1987.]



CATASTROPHIC COVERAGE UNDER MEDICARE

TUESDAY, MARCH 10, 1987

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room H-137, U.S. Capitol Building, Hon. Fortney H. (Pete) Stark (chairman of the subcommittee) presiding.

Chairman STARK. Let the committee come to order. I know you all have been dying to hear my opening statement so I will get that out of the way, if the witness will bear with me, and the Republicans do not really care if they hear that or not.

We are ready to begin our fourth hearing today on extending catastrophic coverage under the Medicare program.

This morning our hearing will focus on the private sector's views on Medicare catastrophic or expanded coverage, and this afternoon we will hear from the medical community, business, and labor.

The Medicare program has been an amazingly efficient program. For 2 cents on the dollar we have covered administrative costs in a program that will spend about \$80 billion in 1987. Equally important, the expanded benefits contained in Mr. Gradison and my bills, H.R. 1280 and H.R. 1281, can be folded into the Medicare program with almost no additional administrative costs.

On the other hand, the private sector has not been able to meet that record. Unlike the Federal Government that pays out 98 cents on the dollar, the GAO has indicated that the weighted average medigap policies pay out only 60 cents. The other 40 cents goes for administrative costs, marketing and profits.

That should not come as a surprise. I suppose it could be argued that those Government costs are costing the taxpayer one way or the other, but nonetheless, between what the beneficiary pays and what they collect, they are better off under the Government programs.

Most medigap insurance companies are indeed very reputable companies, including the witnesses here today. But there are, unfortunately, some who use scare tactics and may frighten the elderly into buying redundant coverage or benefits which really are not benefits to anyone except Danny Thomas and Loren Green.

Consumers Union will provide the subcommittee with testimony on some of the abusive tactics that some medigap companies use, and some 20 percent of the elderly cannot afford to buy any medigap. H.R. 1280 and 1281 will provide about 6 million of those elder-

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ly with benefits that they are not getting from medigap policies without costing them anything.

The insurance industry should have provided catastrophic coverage for hospital and physician expenses, but it has not, and the Medicare program now has the chance to do that.

Under H.R. 1280 and H.R. 1281 the elderly will really know in advance what their hospital and physician out-of-pocket liability will be if we can expand the physician participation program or the knowledge of it.

It's admittedly a first step in providing catastrophic coverage. None of us is quite happy with the name because it pretends more than it will actually provide. But it is a very meaningful first step for those with high hospital and physician bills. I know this committee would look forward to expanding and increasing it. We operate in an era of budget constraints and we will do the best we can at this time.

Before recognizing our first witness, I would like to recognize Mr. Gradison, the ranking member and coauthor of this outstanding legislation.

Mr. GRADISON. Mr. Chairman, it is difficult to improve on your opening statement. At least the end of it sounded very good to me.

Mr. Chairman, I wanted to explain to you and to the witnesses who are going to be here today that at least initially I am going to have to be in a meeting with colleagues on the Budget Committee because they are going to be taking up at 10 this morning the health issues, including Medicare and Medicaid and I think it is important that we be represented over there on some of those issues.

Chairman STARK. If the gentleman would yield.

I know the reason he arrived at this time. It is because he knows the chairman is never here until 15 minutes after the start.

Mr. GRADISON. No, that is not the case. But I did want to explain and apologize that I feel it necessary to start over there and cannot be in both places at the same time.

Thank you, Mr. Chairman.

Chairman STARK. Our first witness is our distinguished colleague from Ohio, Ralph Regula, who has introduced H.R. 1182 which expands greatly on the aid provided to senior citizens. He is here to tell us about it.

Mr. Regula, your entire testimony and without objection, your factsheet on H.R. 1182 will appear in the record in its entirety, and I would invite you to summarize or explain to the witnesses and the committee, or expand on the areas of your bill that you would like to emphasize in any way you are comfortable.

STATEMENT OF HON. RALPH REGULA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO, AND VICE CHAIRMAN, SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE, SELECT COMMITTEE ON AGING

Mr. REGULA. Thank you, Mr. Chairman.

First I would ask unanimous consent to have an article by Drs. Cohen, Tell, and Wallig on risk sharing on nursing homes inserted in the record.

Chairman STARK. Without objection.

Mr. REGULA. Mr. Gradison's comments reminded me, I have to go from here to a hearing in Interior on the National Endowment for the Arts, so we are talking about ministering to the soul as well as the body this morning.

Chairman STARK. No sense living a long time if you cannot enjoy it.

Mr. REGULA. Right. I commend you and your colleagues on this committee for taking on a very much needed but a very difficult task. It is quite a challenge to structure a program that we can address with our budget constraints and still meet the concerns of people. I think it attributes to the success of the health care delivery system that we are here today because the need for catastrophic care as well as access to health care for those under 65 becomes more important as the health care system works more effectively as it has in the past.

And certainly along with direct care, peace of mind is an essential part of good health. I think developing a program in this field would give people a peace of mind that they do not have now because of their concern for what might happen in the event that they are faced with catastrophic medical costs. Plus the 37 million Americans who have no coverage at the moment. And many people are in a difficult spot because they cannot spend down to be eligible for Medicare without dissipating all of their estate while at the same time they do not have the necessary resources to provide the medical care that would give them peace of mind. And that basically covers about 37 million Americans.

There has been a subtle shift of uncompensated care to hospitals and less services and of course that is a shift in public policy that is de facto as a result of the absence of either catastrophic type of coverage for the one in 35 senior citizens that need it, nor having some type of health care program for those under 65, but who are not eligible by virtue of their employment and/or by virtue of being eligible for Medicare.

What I have introduced here is one of many ideas and as you know, Mr. Chairman, there are many different approaches that are being suggested starting with the one from Secretary Bowen and of course including yours and my colleague, Mr. Gradison; also many others.

Essentially what I have proposed here is a three point program, whether it be the catastrophic coverage similar to what is proposed in your bill and Mr. Gradison's. The second would be medical IRA which essentially would offer an opportunity for those who want to self-initiate an IRA program to provide for their own potential disability because of medical problems and/or someone that is dependent upon them.

Obviously, there is a cost to this in terms of the collection of taxes because IRAs do have that impact on the IRS collections. But I think it does provide an opportunity for people to help themselves in ensuring that they do have medical coverage, that they do have the funds necessary in the event they need it for rest homes or skilled nursing homes in their elderly years.

The third approach that is outlined in the bill is to create state-wide pooling corporations. Presently about 11 States have taken

this approach; at this point all stated funded. In essence, what it does is provide access to coverage to those who cannot get it and in some instances through contracts with the private sector the States can ensure that people will have medical health insurance coverage even though they might not be able to afford it.

The proposal I have puts a cap on eligible individuals at 200 percent of the Federal poverty level in terms of income and it is designed basically to use the private sector with the organization being a not for profit or for profit, for that matter, group that contracts with a State to provide this kind of service.

Again, I think here access is very important, because I know that myself in the practice of law that often run into a situation where the husband might die and as a result of his no longer living and the medical coverage that came with his place of employment was terminated and there would be a widow even with minor children that had no access to medical coverage; perhaps had a health record that would not allow access, and it put that individual in a very difficult position and it goes to that question of peace of mind as well as the question of fairness.

What I propose in the statewide pooling cooperations would be a \$2 billion annual block grant indexed to CPI and this would have to be funded with cigarette tax or other type of tax so that there is a cost. Obviously any of these things ultimately have to be paid in some form.

Second, it would require the States to match 150 percent of the total Federal grant. It would allow for the charging of premiums to those persons participating, depending on ability to pay.

And last, it would provide that the private pooling corporation would absorb some of the costs that hopefully they would gain by economies of scale.

Maybe not a perfect answer, but I think one to consider and we can build on the experience of the 11 States that presently have this program. And the essence of all of this is what I think the committee's objective is and that is to provide some kind of coverage for the 37 million people who do not presently have it and also to provide catastrophic care at a reasonable cost to the elderly and of course in the final analysis to give people some security that they do not presently have in terms of their need for health care of varying degrees.

[Statement and attachments of Mr. Regula follow:]

TESTIMONY OF
THE HONORABLE RALPH REGULA, VICE-CHAIRMAN
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE
March 10, 1987

Since the beginning of this decade, changes in the reimbursement policies of Medicare, Medicaid and other third-party payers coupled with the continued growth in medical care costs have brought change to the health industry. Limited by finite payments, providers have been driven into a system of allocating services based to some extent on criteria other than patient need. The uninsured and underinsured are being forced into a two-tiered health care system which restricts access and inhibits quality of care based on the individual's ability to pay.

Medicare beneficiaries face a similar problem. Although our elderly are provided comprehensive acute care they have little public or private protection against the staggering costs of catastrophic care, and particularly nursing home expenses. Medicare pays for less than 3% of all nursing home days. Typically, an individual is placed in a nursing home as a private-paying patient, depletes his or her personal assets, and then becomes eligible for care under Medicaid. Access to care is maintained but the individual is pauperized.

Current trends in the organization and financing of health care highlight the importance of structuring delivery and reimbursement systems to create a minimum package of services to all people regardless of their ability to pay, or age. The federal government has followed de facto policy of discretion toward this matter. Discretion presupposes that the private sector and state and local governments will somehow develop reimbursement and care models consistent with the demands of the general population. Over the past three years, the Aging Committee's Subcommittee on Health & Long-term Care has compiled data regarding catastrophic care and the broader issue of universal access to care. The conclusions of our study indicate that approximately one out of every five Americans is being denied care or receiving less care than adequate due to insufficient health care insurance.

In 1985, some 37 million Americans were without private or public health insurance, an increase of 25% over the previous eight years. Between 1981 and 1983, the years of the recent economic recession, Medicaid enrollees

decreased by 1.1 million rather than increasing an estimated 635,000 to reflect higher unemployment. Those remaining eligible received a 5% reduction in number of visits from 1981 to 1982 alone. At any given time, it is predicted that approximately 1 million Americans are unable to obtain health insurance due to preexisting health conditions and a growing reluctance by health insurers to grant policies to such a person.

Many of the private and public support programs which previously provided the necessary resources for these people have been reduced or eliminated. For example, the main support for the medically indigent, the Medicaid program, has become inaccessible to 54% for all poor families compared to 37% in 1975. With this decrease in coverage the poor have been increasingly forced into the alternatives of receiving care given by facilities structured for non-pay patients or foregoing treatment. The result is an unprecedented increase in uncompensated care to hospitals and less services to the sick, and, more subtly, a shift in public policy for funding health care. Those who are Medicaid-ineligible receive treatment under an informal patchwork of hospitals offering various services at different times based upon their bad debt load and government subsidies. Instead of a guarantee of certain minimal services, care has become a question of the individual hospital's finances.

This fragmented policy does arguably stabilize State and Federal health expenditures. But it does not eliminate the social cost or best utilize existing resources. A recent University of California study found that in comparisons of the health of 186 non-Medicaid poor with 109 Medicaid poor the non-Medicaid group experienced 5 death in a six month period with no deaths reported in the latter group. Three of those deaths were directly attributed to the patient's inability to pay.

Any effort to provide comprehensive health care must also address the issue of cost containment and limited federal resources. Since 1975, the deficit has average 2.5% of the GNP; it increased to 5% of the GNP in 1986. From the period 1965 through 1980 national health care expenditures grew at an average annual rate of 12.5%, and now consume nearly 11% of the GNP. Existing resources must be maximized while seeking ways to reduce overall costs.

I have introduced legislation, HR 1182, which incorporates many of the original recommendations of Secretary Bowen, of the Department of Health and Human Resources, for providing comprehensive coverage to all Americans. Beside the use of Medical IRAs and a limited enhancement of Medicare the proposal sets forth a novel public/private approach known as Statewide Pooling Corporations.

The legislation implements a patchwork of public/private options to provide comprehensive care to all Americans with minimal disruption to the present system in a budget neutral manner. It strongly emphasizes active participation by the private sector, including insurers, HMOs, and other health care providers.

Specifically, the Medicare provision would provide similar coverage to the elderly as set forth in your, and Mr. Gradison's bills HR1280/1281, Mr. Chairman. It would include unlimited acute care and limit out-of-pocket expenses to approximately \$1000 annually. Participation would be voluntary and would be funded by a \$5.00 monthly premium.

The health services accounts, or medical IRAs, would incorporate the traditional benefits of this saving instrument with several important modifications. A distribution could be made from the account at any age for specific health and insurance expenses. Upon distribution the individual would be entitled to a capital-gains treatment of the withdrawal. Only 50% of the total would be included as taxable income if used for the purchase of certified long-term care insurance and 80% of the figure would be included if used for the purchase of direct health care services, such as a physician visit or nursing home stay. The IRA could be funded by the individual or his employer.

Some states have created pools to achieve a more equitable payment mechanism for hospitals that serve a disproportionate number of the poor and uninsured. Structured upon this premise, but more strongly emphasizing private control, is the model of "statewide pooling corporations". These organizations are private corporations (either for-profit or not-for-profit) supported by public and private dollars to purchase insurance or services for eligible state residents. Eligibility would be determined largely by the income level of the resident, being limited to 200% of the

federal poverty level. Participation in the program would be determined by the State. Each state would have one pooling corporation which could contract with other entities for the provision of services or insurance coverage. State and federal governments would maintain oversight and policing functions while the private entity would administer the program in accordance to set criteria.

The pooling corporations would be funded from four separate sources. Federal contributions would consist of a \$2 billion annual block grant indexed to the Consumer Price Index with funds originating from a cigarette tax and a tax upon large employers who fail to provide comprehensive health care packages to their employees. States would be required to contribute at least 150% of the total of the federal block grant. Premiums of up to 50% of the program costs could be charged to those persons participating within the program as long as it does not inhibit participation. Finally, any program costs exceeding these sums would be absorbed by the private pooling corporation.

Critics state that private long-term care insurance is difficult to establish because of the high costs and use patterns by the elderly. Some believe that large infusions of capital will be required to provide comprehensive coverage. I disagree. Instead, much of the cost can be met with a more efficient allocation of existing resources within the private sector. I would like to share with the subcommittee an article by Dr. Marc Cohen, a distinguished scholar of the Health Policy Center of Brandeis University, wherein he states that the expected annual cost per person over age 65 for nursing home care is between \$532 and \$760. These costs are distributed very unequally. Only 13% of the elderly account for 90% of all nursing home expenditures. These statistics indicate the possibility and desirability of long-term care risk-sharing arrangements among the elderly. I offer a copy of this article for the record.

Over one billion dollars a day are spent in our nation on health care, but our system continues to operate below its potential. The United States has the economic and technical resources to provide satisfactory medical services to its total population. Both government, and the private industry, must reevaluate their traditional roles to determine how these resources should best be allocated.

The Lifetime Risks and Costs of Nursing Home Use Among the Elderly

MARC A. COHEN, PhD, EILEEN J. TELL, MPH, AND STANLEY S. WALLACK, PhD

In this paper, we estimate the risk of an individual of entering a nursing home throughout the aging process. We then estimate the expected lifetime costs of nursing home use both for an individual and for society as a whole. The model is based on double-decrement life-table analysis. Data are taken from a 1977 survey of 4,400 Medicare beneficiaries. At age 65, the upper bound for the lifetime risk of entering a nursing home is 43.1%. The risk of entering a nursing home increases with age until around age 80. At about age 85, the risk begins to decline significantly. At almost all ages, the lifetime risk of entry for females is twice that of males. The expected lifetime costs of nursing home care across all ages are between \$10,500 and \$13,600. These costs are distributed very unequally. Only 13% of the elderly account for 90% of all nursing home expenditures. Given current life expectancy, the expected annual cost per person over age 65 is between \$532 and \$760. In the year 2000, the expected annual average costs of nursing home care per elderly person will range from \$450 to \$650. The decline in the average annual cost per person reflects shifts in the age structure and increased life expectancy. These figures need not represent an unmanageable burden on society's resources. Figures presented here help establish the feasibility and desirability of long-term care risk-sharing arrangements among the elderly, like long-term care insurance, life care communities, and other models. Key words: nursing home utilization; lifetable analysis; probability of nursing home entry; lifetime nursing home costs. (*Med Care* 1986; 24:1161-1172)

The largest component of long-term care expenditures for the elderly is nursing home care. In 1982, \$27 billion was spent on nursing home care, most of which was care for the elderly. Of this amount, Medicaid paid \$13 billion, private patients paid \$12 billion,

and Medicare and private insurance made up the remaining \$2 billion.¹ Nursing home payments are the largest single out-of-pocket health care expense faced by the elderly.² If the distribution of private spending parallels that of public spending, then nursing home expenditures represent about 75% of all long-term care expenses.³

Substantial research and policy efforts have been devoted to understanding nursing home utilization patterns and identifying the risk to the elderly of entering a nursing home. Much of this research has been directed toward finding ways to reduce nursing home use and expenditures. There are, however, other reasons to better understand the risk of nursing home entry among the elderly.

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Estimation of nursing home use rates is important to federal and state planners, who must predict budgetary needs. Equally important, the development of new methods to finance and deliver long-term care services requires accurate estimation of the individual risk of incurring a nursing home expense. In addition to the presence of Medicaid and uncertainty about moral hazard and adverse selection, long-term care insurance has been slow to develop because the risk and expected costs of nursing home care for an insured population have not yet been adequately identified. The development of private long-term care insurance depends on accurate projections of patterns of nursing home use.

The growth of prepaid managed care environments, such as the Social/Health Maintenance Organization (SHMOs) and Continuing Care Retirement Community (CCRCs), also known as Life Care Communities, necessitates precise identification of service utilization rates. For the latter, nursing home expenditures are likely to be the single largest financial liability. Thus, predicting nursing home use is necessary to assure financial solvency. Improved forecasting of future long-term care risks can also be useful in the financial planning needs of the elderly and their families.

Although nursing home care comprises the single largest long-term care expenditure, there remains a significant gap in the knowledge base about how many people use nursing homes. The purpose of this paper is to develop a model that can be used to estimate the risk of entering a nursing home, a risk that confronts each individual throughout the aging process. In this way, the expected lifetime costs of nursing home use can be estimated both for an individual and for society as a whole. We will demonstrate that the nursing home liability is distributed very unevenly within the population and that, for most, the expected lifetime costs are not so great.

Previous Research on the Risk of Nursing Home Entry

Although a great deal of research has been done on this topic, there is no clear consensus on the actual risk of an individual entering a nursing home. A frequently cited statistic is that at any one point in time, nearly 5% of the elderly population resides in a nursing home. This point-in-time estimate, however, does not capture the flows in and out of nursing homes. A significant number of people who enter nursing homes leave them within a short time, because nursing homes are often used for short-term recuperative care and not just for long-term custodial care. Kastenbaum and Candy⁴ demonstrated that this 5% figure in no way reflects the true proportion of people who will enter a nursing home in a given time period.

Between 1973 and 1980, a number of researchers, including Kastenbaum and Candy,⁵ Palmore,⁶ Wershow,⁷ and Lesnoff-Caravaglia,⁸ estimated that an individual of a certain age faced between a 25% and a 33% lifetime risk of entering a long-term care facility at some time in his or her remaining years. The method used to obtain these estimates was based on "incidence of nursing home death" research. In essence, the risk of institutionalization was given to be the proportion of those persons over age 65 who died in a nursing home during the course of a year.⁵⁻⁸

This method provides an underestimate of the true risk of institutionalization confronting an individual because it is known that many people who enter a nursing home leave alive after a few months. Also, people who have been in nursing homes for many years may actually be transferred to hospitals or elsewhere before they die. In both cases, these people would not be counted as having resided in a nursing home. Thus, although these estimates represent a distinct improvement over the cruder cross-sectional figure, they are still biased downward.

In the early 1980s, additional studies indicated that these estimates could be off by as much as a factor of two. Vicente et al.⁹ estimated the risk of institutionalization confronting an individual age 65 and over to be 39%. They relied on a modified death certificate approach. In his work on the lifetime risk of nursing home residency, McConnel¹⁰ identified the applicability of double-decrement life-table analysis to this problem and estimated the lifetime risk of nursing home entry for a 65-year-old at 63%. He also stressed the importance of repeat nursing home entry. Many nursing home residents enter a long-term care facility more than once, and this can confound incidence rates derived from cross-sectional data.

Although these more recent studies are improvements over earlier work, they also have a number of problems. First, the Vicente study was based on a sample taken from one county in California; thus, the risk estimates are based on a very specific configuration of service arrangements that may not be applicable to other parts of the United States. Also, McConnel was not able to effectively use life-table analysis with his cross-sectional data, leading to overestimates (Liang J, Jow-Ching Tu E. Estimating lifetime risk of nursing home residency: a further note. Unpublished manuscript, 1985; and McConnel C. Personal correspondence).

In short, the range of estimates for the lifetime risk of entering a nursing home that confronts an elderly individual is from 25% to over 60%. No single method used to develop a risk estimate has been able to deal adequately with the problems of incomplete historical data and/or the lack of data on repeat use of the nursing home—recidivism. Our method is intended to improve on earlier approaches along these lines.

Method

Data from the 1977 Current Medicare Survey (CMS) of 4,400 Medicare beneficiaries were used in the analysis. The CMS

was a survey conducted annually until 1977 to provide detailed information about the socioeconomic, demographic, and health characteristics of a sample of Medicare beneficiaries. The sample survey was self-weighted and designed to represent the universe of persons enrolled for Medicare Supplementary Medical Insurance. When compared with the distribution of characteristics among the entire elderly population in 1977, the CMS corresponds closely. Thus, results can be extrapolated with confidence to the elderly Medicare population in general.¹¹

The survey included people living in the community as well as those living in various long-term care facilities. Our research focused on deriving the risk of entering a nursing home faced by those people living in the community at the beginning of the study period. These people were interviewed at the beginning of the survey year (1977) and again 1 year later to identify whether they used services in various health care settings, as indicated by visits from doctors in these different care settings.

The survey did not query whether a person had actually entered a nursing home; rather, it indicated whether a person had been visited by a physician in a nursing home within 1 year subsequent to the interview date. Thus, for the purposes of our analysis, if a person was visited by a physician in a nursing home, he or she is treated as "having entered a nursing home"; all others are considered not to have entered a home.

Approximately 3% of the sample (125 persons) fell into this category. This 3% figure may be an underestimate since it is possible that a person in our sample could have entered a nursing home and not been visited by a doctor within 1 year subsequent to the interview date. In this case, the person would not have been identified as having entered an institution. Willemain and Mark¹² indicate that, on average, patients in skilled nursing facilities (SNFs) are visited by phy-

sicians at least once every 30 days whereas those in intermediate care facilities (ICFs) are visited about once every 90 days. Thus, depending on the mix of ICF and SNF entrants, the proportion of nursing home entrants in our sample is likely to be between 3.3% and 4.0%. For the elderly population as a whole, however, the range is likely to be greater since statistical error must be added to measurement error. It is quite possible that when we take into account statistical error, the true proportion of entrants is between 3% and 5%.

The data also enabled us to determine whether an individual had died by the end of the survey interval without entering a nursing home or after entering a nursing home. In this way we were able to "break apart" the death rate for those who died in the community (not having entered a nursing home) and those who died after nursing home entry. This helped us to adjust mortality tables to estimate the number of people living in the community in each period who faced the risk of nursing home entry.

As a first step toward estimating the expected lifetime costs of institutionalization, the risk of "nursing home entry" was developed. The approach used is relatively straightforward. To calculate the risk rate, a hypothetical cohort must be "aged." This means that at each age interval, survivors face the twin risks or "double decrement" of either dying (not having entered a nursing home) or entering an institution. In demography, this approach is referred to as double-decrement analysis.¹³ Next, the number of people who have either died or entered an institution is subtracted from the initial population. The same procedure is applied to the survivors repeatedly until the entire cohort has expired. The final step is to add up the number of persons who entered a nursing home and divide by the number in the original cohort. In this way, the proportion of people who actually entered a nursing home is determined.

More specifically, at each age interval, the number of people who survived the previous interval again face the double risk of death in the community or nursing home entry. Thus, the probability of surviving in the community during a given interval can be determined by the following set of relations:

Q^d = Death rate

Q^{nh} = Nursing home entry rate

$(1 - Q^d)$ = Probability of not dying

$(1 - Q^{nh})$ = Probability of not going into a nursing home

$(1 - Q^d) \cdot (1 - Q^{nh})$ = Probability of surviving in the community

From our data we are able to determine the proportion of people in each age interval who enter a nursing home or who die in the community. However, to determine the actual number of people who "expire" or leave the cohort in a given interval, these rates must be adjusted to account for the fact that these events or decrements occur at different times throughout the interval. For example, those who enter a nursing home halfway through the interval will no longer face the risk of death in the community during the second half of the interval. The opposite is also true: those who die in the community halfway through an interval no longer face the risk of entering a nursing home for the remainder of the interval. Analytically, the problem is to estimate the number of survivors facing each risk throughout the interval. For example, if we look at each risk rate individually, the total number leaving the cohort would equal the death rate multiplied by the surviving population plus the nursing home rate multiplied by the surviving population. However, this would be an overestimate of the actual number leaving the cohort since as soon as someone dies the number of people facing the risk of nursing home entry declines. To estimate the actual number of people leaving the cohort as a result of

either death in the community or nursing home entry, the rates are adjusted as follows:

N^d = Number of deaths in community

N^{nh} = Number of nursing home entries

P = Total population

$Q^d = N^d / (P - [\frac{1}{2}(N^{nh})])$ = Adjusted death rate

$Q^{nh} = N^{nh} / (P - [\frac{1}{2}(N^d)])$ = Adjusted nursing home rate

These new rates reflect two assumptions: first, that the distribution of the double decrements is fairly uniform throughout the time interval; and second, the number of people facing the nursing home risk is comprised of all community survivors at the start of the time interval minus one half of those who die in the time interval; conversely, the number of people facing the death risk equals the total number of community survivors at the start of the interval minus one half of those who entered nursing homes during the time interval. The ratio of these two rates (Q^d/Q^{nh}) is called the "force of decrement." For example, if the ratio is 1.4, this means that the force of decrement from death is 40% stronger than the force of decrement from nursing home entry.

The total number of people leaving the cohort at each interval is determined by applying these adjusted rates to the total number of survivors at the start of the time interval. The Central Rate of Decrement is used to allocate the total decrement between those that left the cohort as a result of a nursing home entry and those that left because of death (Powell A, personal communication). Roughly speaking, this allocation is made by comparing the risk ratios for each decrement and multiplying by the total decrement. Summing the number of people across age intervals who left the cohort because of nursing home entry and dividing by the original number in the cohort gives the overall probability of institutionalization across all the intervals.

TABLE 1. Age- and Sex-Specific Rate of Entering a Nursing Home at Least Once During a 5-Year Period

Age Group	Risk		
	Total	Men	Women
65-69	.0485	.0546	.0429
70-74	.0699	.0854	.0581
75-79	.1590	.1180	.1863
80-84	.2300	.1514	.2707
85+	.4770	.2594	.5580

To apply this approach, we need to identify three parameters. The age-specific nursing home entry rate is derived from the 1977 Medicare data set as described above. The proportion of the sample alive at the beginning of an age interval who die during the interval is based on 1977 life tables. The proportion of people alive at the beginning of an age interval who die in the community not having entered an institution is derived from a modification of the 1977 life tables based on the 1977 Medicare data set.

The primary purpose of our study was to estimate the age- and sex-specific risk of entering a nursing home. These risk rates are then used to calculate the expected lifetime costs of nursing home care for an individual and for a specific age cohort. A detailed discussion of our approach is presented below.

Determining the Risk of Nursing Home Entry

Table 1 shows the age- and sex-specific point estimates for the risk of entering a nursing home during a 5-year period.

Between ages 65 and 75, men face a greater risk of entering institutions than do women. However, after age 75, the probability that a woman will enter a nursing home at least once during a 5-year interval surpasses the rate for men. By age 85, for every two women who enter a nursing home, there is slightly less than the equivalent of one male entrant from the same age category.

TABLE 2. Proportion of People Alive at the Beginning of an Interval Who Die During the Interval

Age Interval	Total Population	Men	Women
65-69	.1173	.1605	.0815
70-74	.1764	.2354	.1303
75-79	.2647	.3384	.2136
80-84	.3612	.4391	.3136
85+	1.0000	1.0000	1.0000

Table 2 shows the proportion of people alive at the beginning of an age interval who die during the interval. The death rates of men and women do not follow the same pattern as do the differences in their relative risk rates. At all age intervals, men have a higher death rate than do women. However, in the older age categories, this difference in the death rates lessens, indicating that survivors in both groups share a similar mortality experience.

Table 3 shows what happens to a hypothetical population of 100 people aged 65-69 as they age. To determine the lifetime risk of nursing home entry for this cohort, we simply sum the number of people in the cohort who experienced the event "nursing home entry" and divide by the number of people in the cohort, in this case 100. The sum is 43.1, which means that a person who reaches age 65 faces a 43.1% chance of entering an institution at least once before he or she dies. The 95% confidence interval around this point estimate is from 40.1% to 46.1%.

It is also possible to estimate the remaining lifetime risk for people at different age levels. For example, a person reaching the age of 80 faces a 48% chance of entering an institution in the remaining years before death. Given the smaller sample sizes for people in the older age groups, the 95% confidence intervals around the point estimates are larger. For example, while the point estimate for the lifetime risk of nursing home entry of 85-year-olds is 43.0%, the 95% confidence interval is from 36.0% to 50.0%.

Table 4 shows the lifetime risk of nursing home entry for men and women by different age intervals and the change in the risk rate between intervals. The lifetime risk of entering a nursing home for a 65-year-old person is higher than earlier research would suggest but lower than that suggested by later research. We find that the risk of entering a nursing home increases with age, although at a decreasing rate, at least until around age 80. At about age 85, the risk actually begins to decline significantly. Since mortality rates are increasing with age, it is not surprising that the rate of increase in the risk of entry is declining; fewer people are surviving long enough to enter a nursing home. Those who have survived to age 85 are likely to be healthier individuals and suffer from fewer chronic illnesses. For them, death, not nursing home entry, is more likely to be the cause of their leaving the cohort.

For women, the risk of entering a nursing home increases with age, at least until the age of 80. The rate of increase in the risk begins to decline after age 80 and even turns

TABLE 3. The Aging of a Hypothetical Cohort Aged 65-69

Age Group	Number Who Face Risks	Number Who Leave Cohort	Adjusted Nursing Home Entry Rate	Decrement From Nursing Home Entry
65-69	100.00	14.362	4.84	4.84
70-74	85.64	18.104	6.98	5.98
75-79	67.53	22.579	15.84	10.70
80-84	44.96	21.203	22.93	10.31
85+	23.75	22.529	47.54	11.29

significantly negative by age 85. This indicates that after age 85, the risk of nursing home entry for women actually declines.

The pattern for men is quite different. Between ages 65 and 74, there is only a very slight increase in the risk rate. After age 75, the risk begins to decline and does so at an increasing rate. It may be that the most "fit" males are surviving and thus are less likely to use a nursing home before they die. For men, the group facing the highest risk is ages 70-74; whereas for women, the 75-79 age group faces the highest risk. Across all age groups, women are one and one-half to two times more likely to enter an institution than their male counterparts. Because we are estimating risk rates for subgroups in our sample, the standard errors around the point estimates are likely to be substantial. As well, in a multivariate equation, differences in risk rates attributable to sex may be minimal when other variables such as marital and health status are accounted for. Therefore, differences in the estimates for men and women must be viewed with these caveats in mind.

There are a number of factors that might explain these patterns. First, mortality figures indicate that across all age categories, men face a much greater risk of dying than do women. This means that fewer men survive to later ages to face the risk of entering an institution. Closely related to mortality is morbidity. Often, the incidence of different illnesses increases during the last years of a person's life. Since greater proportions of men die at younger ages, we would expect to see higher rates of nursing home use also during the earlier age intervals. Our data indicate that, indeed, interval risk rates for men are higher than those for women through age 74 and that the risk rate for men peaks at ages 70-74, whereas for women the greatest risk is faced by the 75-79 age group.

Another factor relates to informal supports. The availability of social supports is closely linked to nursing home use.¹⁴ Because

TABLE 4. Lifetime Risk of Nursing Home Entry at Different Age Levels and Change in Risk

Age Category	Total Population	Remaining Risk of Entering an Institution	
		Men	Women
65-69	43.1%	30.5%	51.9%
70-74	44.7% (+1.6)	30.6% (+0.1)	53.4% (+1.5)
75-79	47.7% (+3.0)	29.7% (-0.9)	57.4% (+4.0)
80-84	47.6% (-0.1)	27.6% (-2.1)	57.3% (-0.1)
85+	43.0 (-4.6)	22.9% (-4.7)	52.0% (-5.3)

of life expectancy differences and the general pattern of older men marrying younger women, there is a much greater probability that an older man will be married, whereas an older woman will more likely be single. Thus, even if two people are alike in all other relevant respects, there is a greater probability that the man will have available informal supports to help keep him out of an institution. In contrast, the woman is more likely to be alone and hence faces a greater risk for needing institutional care.

As previously mentioned, repeat nursing home use or recidivism must be taken into account in analyses that use cross-sectional data to make longitudinal risk estimates. This is because risk is determined in part by the number of nursing home entries for a particular age group. If, for example, recidivism were not accounted for in the analysis, then a person entering a nursing home at age 66 and then again at age 80 would be counted twice—first as a 66-year-old entrant and then as a different 80-year-old entrant. In fact, although there may be two or more entries, only a single individual experiences them. Thus, the number of entries must be adjusted assuming different proportions between the number of entries and the number of unique individuals entering nursing homes throughout their lifetimes.

To account for the impact of repeat nursing home use, we approximated lifetime risks assuming different levels of recidivism (see

Appendix 4). For purposes of illustration, we made the simplifying assumption that repeat use remains constant across the cohort. In reality, the proportion of admissions that are recidivist probably increase with age. If, for example, 30% of all current entrants have previously been in a nursing home, then entry rates for each of the 5-year intervals must be adjusted downward. In this case, the entry rate for a 5-year interval would be adjusted downward by 30%. These new rates would then be cycled through our double-decrement model to obtain the total lifetime risk. By accounting for recidivism, the total lifetime risk is reduced.

We find that for those aged 65-69, the point estimates for the lifetime risk of entering an institution range from 33.5%, when we assume a 30% rate of recidivism, to 43.1%, assuming a zero recidivism rate. The 1976 Survey of Institutionalized Persons indicates that roughly 18% of all nursing home residents had been in a nursing home at least one other time prior to their current stay.¹⁵ It is difficult to know whether this 18% is an overestimate or underestimate for the proportion of entrants that may be recidivists. If nursing home residents are older than nursing home entrants, then perhaps they are more likely to have had multiple entries at younger ages. This would make the 18% figure an overestimate for recidivism among entrants. It might be, however, that the 18% of residents who are recidivists represent short stayers, who would be underrepresented in a cross-sectional sample. If being a short-stayer is associated with greater repeat use, then the figure from the Survey of Institutionalized Persons would be an underestimate of recidivism among nursing home entrants. Either way, by accounting for recidivism, we reduce the risk estimates.

Implications for Long-Term Care Costs

Most of the literature on nursing home use looks at the issues of risk and cost separately.

The literature on risk focuses almost exclusively on the incidence of nursing home use and the characteristics related to use. The cost literature emphasizes gross public and private expenditures and only rarely focuses on the amount of money nursing home entrants can expect to spend over their lifetimes.¹⁶⁻¹⁸ In this study, we use our risk estimates to project the expected lifetime costs of nursing home care for an elderly entrant as well as for all elderly.

Both the risk and cost estimates developed in this paper reflect a very specific configuration of service arrangements and reimbursement policies. Current use is constrained by both bed supply and the reimbursement policies of the Medicaid system. Changes in the long-term care environment will mean changes in cost and risk estimates. It is likely that in a world with either substantial long-term care insurance or prepaid managed-care environments such as CCRCs, future risks and costs will differ from current estimates. This is because nursing home use patterns are a function of systemic factors as well as client demographic and behavioral characteristics. This is evidenced by the fact that the risk rate varies by geographic region. Also, the sex and marital, health, and mental status of a particular elderly person inevitably affect risk rates. In short, our risk estimates reflect an average across the United States; this average is a function of the structure of the current long-term care system as well as the characteristics of the current cohort of elderly persons.

We estimate expected lifetime costs by combining our risk estimates with length-of-stay data from the 1976 National Nursing Home Discharge Survey. We assume an average daily nursing home cost of \$55.00. We find that the average lifetime cost per nursing home entrant assuming no repeat use and no discounting is between \$24,500 and \$28,600.

In order to determine the expected life-costs per elderly person in a specific age cohort, we must make use of our point esti-

mates for the probability of nursing home entry. For example, someone in the 65-69 age cohort faces a 43.1% chance of entering a nursing home; thus, when we estimate the expected lifetime costs for all members of this age cohort, we arrive at a per-person figure of \$11,500.

As Table 5 indicates, the expected lifetime costs of nursing home care across all ages are between \$10,500 and \$13,600, assuming a zero rate of recidivism. The costs for women are nearly twice as high as those for men. The range for women across all age groups is between \$12,800 and \$16,400, whereas for men the range is from \$5,600 to \$8,200. The age cohort with the highest expected costs are the 75-84-year-olds. Those over age 85 have the lowest expected costs because fewer of them enter nursing homes and those that do stay for shorter periods of time.

The distribution of expected costs is especially interesting. For most entrants, the expected lifetime costs are much less than \$10,000. Only a very small percentage of entrants, 14-17%, account for about two thirds of all nursing home expenditures. This is explained by the high degree of variance in the length-of-stay patterns among nursing home entrants. The majority of nursing home entrants (75%) stay less than 1 year, and one third to one half of all entrants stay less than 3 months. About one fourth of all entrants stay beyond 1 year, and very few (14-17%) stay more than 3 years.¹⁹⁻²³

When we analyze nursing home expenditures across the entire elderly cohort, we find that 3.6% of all elderly use about 43% of all nursing home resources; another 6% use 40% of total nursing home resources. Alternatively, roughly 90% of all elderly use somewhat less than 13% of all nursing home expenditures. Compared to the distribution of hospital resources across the elderly population, nursing home expenditures are distributed much more unequally.²⁴ Figure 1 shows the percentage of nursing home ex-

TABLE 5. Expected Lifetime Cost of Nursing Home Care by Age Cohort Assuming Zero Recidivism

Age Cohort	Expected Lifetime Costs		
	Total Population	Men	Women
65-69	\$11,500	\$8,100	\$13,800
70-74	\$11,900	\$8,200	\$14,200
75-79	\$13,600	\$8,500	\$16,400
80-84	\$13,600	\$7,900	\$16,400
85+	\$10,500	\$5,600	\$12,800
Average	\$12,000	\$8,000	\$14,580

pensitures attributable to different proportions of the elderly population. The area between the curve and the 45-degree line represents the extent of "inequality" in the distribution of nursing home expenditures among the elderly. As is shown, a very small proportion of elderly consume a disproportionate share of nursing home resources.

The effect of recidivism on lifetime costs is somewhat complex. Recidivism reduces the estimate for the lifetime risk of entry for a group but adds to the average duration of stay for entrants when their multiple admissions are added together. Thus, the lifetime costs *per entrant* rise with recidivism. If we assume that all episodes of nursing home entry are similar, independent of whether they are for a person with a single admission or one with multiple admissions, then the costs *per episode* of nursing home care remain unaffected by recidivism. If, however, the characteristics of a recidivist episode differ from a non-recidivist episode, there is an effect on the cost per episode of nursing home care.

The National Nursing Home Survey indicates that stays of live discharges from nursing homes are shorter than the average for all discharges. If we assume that the primary source of recidivism is short-stayers (who have the opportunity to become recidivists), then the average duration for nursing home entrants, including those with multiple

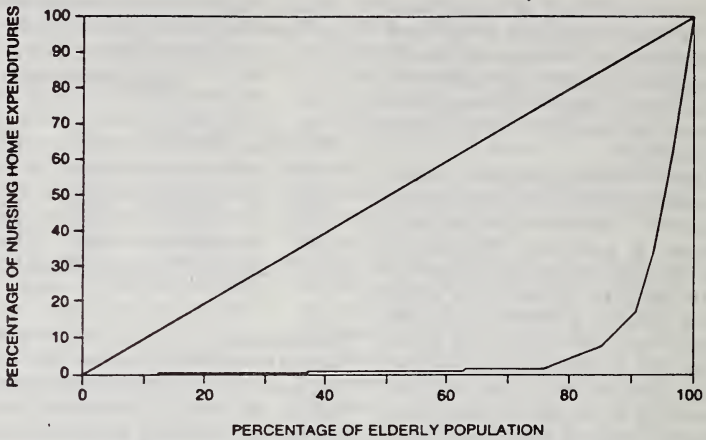


FIG. 1. Lifetime nursing home expenditures attributable to various proportions of the elderly population (Lorenz curve).

entries, may not be that much greater than the average total duration of all entrants. Thus, costs *per entrant* may not increase nearly as much as the probability of entry for the group declines. For this reason, the lifetime costs spread over the entire cohort will decline; it then follows that the lifetime costs *per elderly person* will decline somewhat.

We can also estimate the total nursing home resource costs for a particular age cohort by multiplying the number of people in the cohort by the expected lifetime costs per

person. For example, in 1982, there were 16.0 million people aged 65–74. These people will consume between \$131.8 and \$188.4 billion in nursing home resources, depending on the extent of recidivism. Table 6 summarizes the estimated cohort costs of nursing home use for the years 1982, 2000, and 2020.

Given current life-expectancy figures, the expected annual cost per person over age 65 varies between \$532 and \$760. This does not represent an unmanageable burden on society's resources. The estimated annual liability represents about 23% of per capita personal health care expenditures on the elderly. Moreover, such costs represent less than 10% of the total health bill in the United States.²⁵ These figures also indicate the feasibility of insuring for nursing home costs either through long-term care insurance or various managed prepaid care plans.

Today there are about 28 million people aged 65 and over. By the year 2000, this number will grow to about 35 million, and by 2020, there will be nearly 55 million peo-

TABLE 6. Total Lifetime Cost of Nursing Home Care by Age Cohort Assuming Zero and 30 Percent Rates of Recidivism

Age Cohort	Total Cohort Costs		
	1982	2000	2020
65–74	\$131.8–188.4	\$145.4–207.7	\$244.6–349.4
75–84	\$78.7–112.4	\$116.6–166.5	\$136.4–194.8
85 and over	\$18.1–25.8	\$37.9–54.2	\$54.2–77.4

ple over age 65.²⁶ If we assume no major changes in the finance and delivery of long-term care services and if the profile of the elderly remains roughly similar, then by the year 2000, approximately 11-15 million elderly will enter nursing homes for some period. The expected lifetime costs of care for all elderly people will average between \$8,500 and \$12,200. The projected remaining years of life for those aged 65 and over in 2000 are 18.8 years.²⁷ Thus, in the year 2000, the expected annual average costs of nursing home care for an elderly person will range from \$450 to \$650 (1982 dollars). By 2020, the expected annual costs will range from \$430 to \$615 per person (1982 dollars). The changes in cost per person over the 40-year period reflect shifts in the age structure toward the "old-old," that is, those aged 85 and over. These figures are likely to be somewhat underestimated because we assume that increases in life-expectancy will have no effect on nursing home use per person; that is, we assume that all of the "extra years" of life are spent out of the nursing home.

Policy Implications

In this paper we have developed a model that can be used to estimate the risk of entering a nursing home, a risk that confronts an individual throughout the aging process. When we assume a zero rate of recidivism, our risk estimates are upper bounds on the actual risk rate. In contrast to previous research, we have looked at how the risk of nursing home use differs for men and women. We have also tried to show how recidivism affects the risk rates and the lifetime cost of nursing home use even though there are few data on repeat use. When data on recidivism becomes available, risk estimates can be refined. Finally, we have attempted to cost out the implications of these risk rates for individuals and for society as a whole.

For a number of reasons it is important to identify the cost of nursing home use per person and not just the cost per entrant. First, many of the new and planned long-term care finance and delivery options are based on risk-sharing arrangements that necessitate precise estimation of the expected lifetime or contract costs for each enrollee. Second, improved forecasting of expected costs can assist the budget and planning processes of federal and state governments and can aid families in their financial planning to meet future long-term care needs.

Our assertion that the costs of nursing home care do not represent an unmanageable burden on society's resources or portend significant problems in the future rests on the assumption that there will not be major changes in the finance and delivery of long-term care services. The cost estimates in this paper point to the desirability of long-term care risk sharing arrangements among the elderly, like long-term care insurance, life care communities, and other models.

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Appendix. Approximations for the Effect of Recidivism on Risk Rates by Age

Recidivism Rate	Risk of Entering a Nursing Home by Age				
	65-69	70-74	75-79	80-84	85 and over
0%	43.1	44.7	47.7	47.6	43.0
15%	39.4	40.4	43.1	42.8	38.8
30%	33.5	35.0	36.7	35.5	31.2

Note: A 15% recidivism rate means that 85% of the nursing home entrants across all age intervals are entering for their first time; the other 15% are assumed to have entered at least once before in an earlier age interval. Because we are summing the number of nursing home entrants, not entries, over multiple age intervals, the age interval risk rates must be adjusted downward.

NEWS

Select Committee on Aging

U.S. House of Representatives

RALPH REGULA, Ranking Minority Member
Subcommittee on Health and Long-Term Care
2209 Rayburn House Office Building
Washington, D.C. 20515
202/225-3876



FACT SHEET -- HEALTH SERVICES ACT OF 1987

(HRL182)

In General

(1) Health Services Accounts

(A) Creates a personal savings account (Health Services Account) for certain health care expenses under similar structure of traditional IRAs.

(B) Two classes would be permitted a deduction (of the deferred income) up to \$2000 in the taxable year when placed in the account:

individual -- any person filing a federal income tax form during a taxable year and who has paid into the account

employer -- any employer who pays an amount in cash for the taxable year on behalf of an employee to the account

(C) Up to 50% of the distribution from the account (when withdrawn) would not be included in taxable income if used for certain health costs

(2) Limited Enlargement of Medicare -- enlarges Medicare Part A to include limited catastrophic care coverage on a voluntary basis.

(3) Statewide Pooling Corporation -- enables States to develop (by their option) a state pool to provide insurance coverage and direct health services to low-income persons with neither public or private insurance.

(4) Is budget neutral and does not create any new entitlement programs.

SECTION 1. DEDUCTIONS FOR CONTRIBUTIONS TO HEALTH SERVICES ACCOUNTS

Structure of Health Services Accounts

(1) Is a trust organized in the U.S. exclusively to pay for qualified health services (defined below) provided to the distributee.

(2) Contributions must be in cash not exceeding \$2000 in a taxable year.

(3) Trustee must be a bank or similar person.

(4) Interest of the distributee in the account is nonforfeitable.

Qualified Health Services Defined

(1) Refers to health expenditures that may be made from the account (expenses must also meet the conditions of medical care under Sec. 215(d)):

direct expenses -- a. care at a skilled nursing facility
b. care at a intermediate care facility
c. certain other long-term care facilities licensed by the State
d. home health care provided by a licensed agency

indirect expenses -- a. medicare supplemental policies
b. health services supplemental policies

Establishment of Health Services Supplemental Policies

(1) In general, defined as a health insurance policy or other health benefit plan offered by a private entity to an individual which provides reimbursement for expenses incurred for catastrophic and long-term care.

(2) Requires Secretary in consultation with various parties to set forth in a report, one year from enactment, regulations providing for the application of standards regarding health services supplemental policies.

(3) Based upon such report the Secretary shall establish a procedure (similar to that used for Medicare supplemental policies under which a health services supplemental policy may be certified by the Secretary as meeting such minimum standards and requirements.

(4) Any distribution from the fund for a non-certified policy is not considered to be a payment for qualified health services and is subject to the penalties for such distributions.

Tax Treatment of Expenditures/Distributions From the Account

(1) In general, any distribution of funds from the account is included in taxable income at 100% for the taxable year when distributed, except:

(A) Any distribution made for expenses other than qualified health services shall be included in taxable income at 100% plus a 10% penalty

(B) Any distribution made for qualified health services direct expenses shall be included in taxable income at 80% of the amount

(C) Any distribution made for indirect expenses shall be included in taxable income at 50% of the amount

Impact on Non-Itemizers

(1) The deduction is permitted to non-itemizers.

SECTION 2. MEDICARE OPTION FOR CATASTROPHIC CARE

Limited Catastrophic Care Coverage Under Medicare on a Voluntary Basis

(1) Establishes an elective catastrophic care option under Medicare which includes the following elements:

- (A) Permits an unlimited number of days for inpatient hospital care
- (B) Eliminates coinsurances added to the Part A deductible
- (C) Current 1/8 coinsurance in skilled nursing facilities is eliminated
- (D) Establishes a maximum of two Part A deductibles in a year
- (E) An increase in premiums (\$5/mo) under Part B on a voluntary basis

SECTION 3. ESTABLISHMENT OF STATEWIDE POOLING CORPORATIONS

In General

(1) Creates a triad between the private sector (employers and insurance companies), state and federal government to provide universal access to care by low-income persons who have neither public or private insurance.

(2) A State-wide pooling corporation (either a profit or not-for-profit private corporation) is established to purchase either insurance and/or direct health services for qualified residents of the State.

Requirements of the Corporation

(1) Must purchase and make available 'levels of insurance' (insurance or direct health services) to qualified residents of a State.

(2) A resident is eligible if a state pool exists and the individual:

- (A) is not eligible for Medicare or Medicaid
- (B) is not a participant in an employer group health plan whose employer is a 'participating member'
- (C) has taxable income less than 200% of the poverty level and meets such other income requirements as established by the State

(3) The 'levels of insurance' must meet the following minimum criteria:

- (A) out of pocket expenses limited to \$1000 for an individual and \$2500 for family coverage
- (B) no lifetime benefit limit of less than \$500,000
- (C) deductible cannot exceed \$1000 for individual coverage
- (D) coverage for pre-existing conditions can be denied for a period not to exceed 6 months
- (E) these requirements apply equally to both insurance coverage and plans which provide direct health services (HMOs, hospitals, etc.)

(4) Enter into a contract with the State for the performance of their duties.
requirements of the State

(1) Have the sole authority to initiate, submit and have approved an application to establish a Corporation to the Secretary of HHS.

(2) Police the activities of the Corporation, review the 'levels of insurance' and report to the Secretary its findings.

(3) Contribute funds to the Corporation for the state pool equal to not less than 150% of the federal block grant.

(4) Establish income requirements for determining eligibility of residents (but cannot exceed 200% of the poverty level).

(5) State may charge a premium to qualified residents participating in the pool

Requirements of the Secretary

(1) Approve and certify Corporations as presented by a State.

(2) Review the 'levels of insurance' provided by a Corporation (every 24 months) as based on State reports and recommendations.

(3) If violations are present can reduce direct grant by up to 50% as modified by good faith efforts by Corporation.

Federal Health Insurance Trust Fund

(1) Establish a trust fund for funding a block grant program (the total amount is capped and indexed to the CPI) for the state pools.

(2) Each State's direct grant is calculated based upon the number of persons participating in the state pool as compared to the national total.

(3) The trust fund is funded exclusively by taxes on tobacco/smokeless tobacco (50% of collected taxes) and employers (over 100 employees) who are not 'participating members' in an existing state pool.

(4) An employer is exempt from tax if he has group health insurance for all employees which meets the minimum requirements for 'levels of insurance'.

(5) Small employers (under 20 employees) are permitted a deduction at a rate of 150% of the expenses paid for a group health plan.

Chairman STARK. Thank you Ralph. I would bet you that you would not find one dissenting vote on this subcommittee in terms of the benefits that you outline or the need for this kind of coverage.

The only concerns that we have are how we pay for it.

Mr. REGULA. I understand that.

Chairman STARK. You and Secretary Bowen have both come up, and some of the members of this subcommittee have toyed around, with ideas of some kind of savings programs. We set aside IRAs last year, and it was not easy. It was not easy for those who wanted to do it and had to suffer the complaints, and argue with their colleagues.

But as I recall, and Hal might correct me, we were talking about \$16 billion.

Mr. DAUB. \$17 billion.

Chairman STARK. \$17 billion? They worked too well, and they tended to work for the higher income people. So we still need a lot of people one would suspect.

Now I would like to figure out a way—to the extent we still have some accumulation shelter in a home—to accommodate people to annuitize that equity, maybe through some kind of FHA insurance for the reverse annuity to encourage lenders to do it.

I think there might be something there. It is just a question of how much you are going to let—the people who are affluent enough to save, I am perfectly willing to make it easy for them to put it aside for long-term care. But that is a problem.

I am not so sure that the States who can do it voluntarily have not already done it. I am not so sure that the political forces in a variety of States are going to say, without some kind of Federal mandate, that you would tax the plans, all the plans, the insured and the self-insured plans, in a State where they do not have a pool. I mean that is more that just encouragement. That is pretty much blackmail but it ought to get the States to do—even in risk pooling where it is inconceivable to me that everybody does not win on that one, the insurance companies and the manufacturers or employers and the people.

But that kind of progress is made slowly. We just want to be tougher with what you are asking the States to do voluntarily, or find ways to encourage them. And again if we all sit over here with this budget neutrality issue that we will have, that is what we have to do.

The final issue, and this is where I am really between a rock and a hard spot. I share with many of the members of this committee not an abhorrence but a real reluctance to deal with dedicated taxes—and not because I do not have a lot of issues like cigarette taxes that I would love to dedicate to the Medicare trust fund—but then I am in a box with what I say to my friend, Mr. Van Derghet, if I do not want to dedicate taxes for the Olympics, or if I do not want to dedicate taxes for a peace academy or a war. Once you start down that road, you have trouble.

I would think that we have more direct empirical evidence between smoking and those costs, if you wanted to talk about user fees, and then I get into the parochial issue of how do I deal with wine, except that we all know about the recuperative—

Mr. REGULA. The Bible said it had medical benefits.

Chairman STARK. Ohio and California wines I suspect do. [Laughter.]

And if I can get some help from New York, well, maybe we would find a way to include their wine too.

But those are the problems, and I just hope that we can get allies for what we are trying to do in this committee so that the perfect does not have to do battle with the somewhat better. And we would like to expand this.

If we wait until we can have the whole pot at once, I am afraid we will not make any progress. So I hope that you will continue your interest and support for whatever expansion I think we both want.

I appreciate your interest and your help because you are absolutely right, this is just a vast unsolved problem and we have a chance to deal with it.

Mr. REGULA. I appreciate that, Mr. Chairman, and I think ultimately society is going to address it in one for or another because we are not—we are compassionate people and we do not want those that need it to go without medical care, so it becomes a matter of which is most cost effective in terms of accomplishing that objective.

Chairman STARK. Senator Daub.

Mr. DAUB. It is just like Friday, the 13th is coming. I just wish you would be a little bit careful about how you address me, for a while, Congressman.

Thank you very kindly though. I do appreciate that.

Ralph, I have known you for a long time. We have served side by side together on the Aging Committee for 4 years, and you are a leader in health care issues and problems of the elderly and particularly on the Subcommittee on Health and Long-Term Care.

I appreciate the thoughtful and innovative suggestions that you have put into your legislation. The chairman has indicated his desire to put first things first and to do what we can do, however that might be designed or defined as possible, and maybe all the other things we would like to do have to be put off a little while.

I take somewhat the opposite view. It is compatible, of course, ultimately with what Chairman Stark would like to do and he is perhaps being more of a realist than I. But I do think we need to have the quid pro quo. I think we have to do something that is private sector oriented along with this expanding the payment for covered services. And that is where I think we are missing an opportunity.

If we believe there is a catastrophic problem, if we believe that the near-poor are more in jeopardy than those who are Medicare qualified or those who are better off, then we need to figure out a way—if we are not going to add some kind of a long-term care nursing home coverage to this legislative initiative this year—we at least ought to add an incentive for individuals and for the private sector to be better prepared to intervene again for that truly long term and catastrophic problem of health care in nursing homes and in the home.

So I like your ideas. I think they are headed in the right direction. We appreciate your being here today and want to thank you for your support and efforts.

Mr. REGULA. I thank you, and we have tried to involve the private sector in this approach as much as possible and still give people security.

Mr. DAUB. Thank you.

Chairman STARK. Mr. Gregg.

Mr. GREGG. I think we are all in the same wave length. Once again it is a question of how we pay for it.

Mr. REGULA. That is right.

Chairman STARK. Thank you very much.

Mr. REGULA. Thank you, Mr. Chairman.

Chairman STARK. We will hear first this morning from the General Accounting Office, Michael Zimmerman, the Senior Associate Director of the Human Resources Division. I see we have Thomas G. Dowdal and Roger Hultgren accompanying Mr. Zimmerman. If you would like to proceed any way you would like.

STATEMENT OF MICHAEL ZIMMERMAN, SENIOR ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY THOMAS G. DOWDAL, GROUP DIRECTOR, AND ROGER HULTGREN, EVALUATOR

Mr. ZIMMERMAN. Thank you very much.

Let me say a little bit about Mr. Hultgren. He was responsible for the work we did on the medigap insurance and that is why he is with me today. And Mr. Dowdal is responsible for much of our work in the Medicare area.

We are pleased to be here today to discuss the report that we prepared for the subcommittee last year on the Federal standards designed to protect the elderly from substandard and overpriced medigap policies. That report focused on how well these objectives were being met in view of what was envisioned when the standards were enacted in 1980.

You expressed particular interest in the medigap policies, loss ratios; that is, the percent of premiums returned to policyholders as benefits.

The Congress enacted the medigap requirements in 1980 because of revelations that some policies were providing very low benefits in relation to their premiums and because of abuses that had occurred in the marketing and selling of policies.

The provision commonly known as the Baucus amendment for its principal sponsor in the Senate, established minimum standards for loss ratios, set requirements for minimum coverage of benefits and provided criminal penalties for abusive sales practices.

To evaluate whether policies being marketed as medigap insurance meet the standards of the Baucus amendment, we reviewed 142 policies and obtained loss ratio data for 394 individual and 4 group policies sold by 92 commercial firms and 13 Blue Cross/Blue Shield plans. Premiums collected nationwide on the 394 individual policies totaled over \$2.1 billion in 1984. The total estimated medigap market in that year was about \$5 billion.

Overall, we found that the Baucus amendment was meeting its objectives. It had encouraged State adoption of medigap insurance regulatory programs at least as stringent as the Federal standards and only four States have not done so as of September 1986. This

has resulted in more uniform regulation of medigap insurance and increased protection for the elderly against substandard and overpriced policies.

As mentioned earlier, the Baucus amendment established standards for anticipated loss ratios; that is, the expected loss ratio had to be at least 60 percent for individual policies and 75 percent for group policies. The law does not require that actual loss ratios meet these requirements, but only that the actuarially determined expected loss ratios do so.

The actual loss ratios of most policies we obtained data on were below the Baucus amendment targets. However, the loss ratios of the policies of most of the Blue Cross/Blue Shield plans and the Prudential Life Insurance Co. were generally above the targets. These were the policies most commonly purchased.

For the individual policies of commercial insurers studied, the weighted average loss ratio was about 60 percent for 1984. In other words, \$770 million in benefits were returned for the \$1.3 billion in premiums paid. Thus, for every \$1 in premiums, 60 cents was returned as claim payments or used to increase reserves, and 40 cents represented administrative and marketing costs and profits. The same figures for the Blue Cross/Blue Shield plans studied are 81 cents in benefits to 19 cents in costs and profits on premiums of about \$770 million.

We recently obtained data on 1985 loss ratios. These 1985 loss ratios were basically the same as those for 1984. Generally changing by only 1 or 2 percent. Overall, the commercial policies had a weighted average loss ratio of 65.8 percent versus a 1984 ratio of 65.4 percent, or a difference of four-tenths of 1 percent.

The Blue Cross/Blue Shield plans we had data on had a weighted average loss ratio of 88.6 percent versus a 1984 ratio of 86.5 percent.

As pointed out in our report, medigap policies are not catastrophic insurance for acute or long-term care. They do not place a limit on policyholder out-of-pocket expenses and, in fact, can limit benefits for part B type services to \$5,000 per year, after which benefits for these services cease.

Medigap policies could be changed to become catastrophic acute care insurance. Insurers then could either increase their premiums to cover the anticipated increase in benefit payouts, or choose to absorb all or part of the increase, thereby increasing their loss ratios. We do not know what, if any, proportion of the extra cost insurers would decide to absorb because this depends on their willingness to earn lower profits on this line of business. On the other hand, if there is a Medicare-administered catastrophic plan, the payouts on insurance for beneficiary out-of-pocket costs below the catastrophic threshold, that is, what medigap insurance would become, would be lower than under current medigap policies. Insurers could decrease premiums to reflect all or part of the decrease or use the lower payout to increase profits.

In addition, administrative costs for a Medicare-administered catastrophic program should be minimal, and benefit payouts should represent virtually all of such a program's costs. Regardless of difference in cost to beneficiaries, there should be several advantages

for beneficiaries to a Medicare-run catastrophic insurance plan over one administered by the private sector.

First, Medicare would make such insurance universally available to Medicare beneficiaries. Commercial insurers, on the other hand, generally can pick who they insure and can choose not to insure individuals.

Second, beneficiaries would only need to submit one claim. If administered by the private sector, presumably two claims would need to be submitted—one to Medicare and, after that claim was paid, another to the private insurer.

Finally, if a catastrophic acute care insurance program for Medicare beneficiaries is established, there will probably continue to be a demand for medigap-type policies. We believe that at least some portion of beneficiaries will still seek insurance against the out-of-pocket expenses they incur before the catastrophic limit is reached.

This concludes my prepared remarks, and we would be glad to answer any questions you have.

[Statement of Mr. Zimmerman follows:]

STATEMENT OF MICHAEL ZIMMERMAN, SENIOR ASSOCIATE DIRECTOR,
HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the report that we prepared for the Subcommittee last year on the federal standards designed to protect the elderly from substandard and overpriced Medigap policies. That report focused on how well these objectives were being met, in view of what was envisioned when the standards were enacted in 1980.¹ You expressed particular interest in the Medigap policies' loss ratios--that is, the percentage of premiums returned to policyholders as benefits.

Baucus Amendment Meeting
Its Objectives

In June 1980, the Congress established requirements that insurance policies must meet in order to be marketed as Medigap policies. The Congress acted because of revelations that some policies were providing very low benefits in relation to their premiums and because of abuses that had occurred in the marketing and selling of policies. The provision, commonly known as the Baucus Amendment for its principal sponsor in the Senate, established minimum standards for loss ratios, set requirements for minimum coverage of benefits, and provided criminal penalties for abusive sales practices. The Baucus Amendment was designed to encourage state regulation of Medigap policies. It included a federal policy certification program to enable marketing of Medigap insurance in states that did not regulate Medigap insurance in accordance with the federal standards.

To evaluate whether policies being marketed as Medigap insurance met the standards of the Baucus Amendment, we visited nine states and the District of Columbia that had laws and/or regulations at least as stringent as the federal standards and two states that did not. We reviewed 142 policies for compliance with the federal standards and obtained loss ratio data for 394 individual and 4 group policies sold by 92 commercial firms and 13 Blue Cross/Blue Shield plans. Premiums collected nationwide on the 394 individual policies totaled over \$2.1 billion in 1984. The total estimated Medigap market in that year was about \$5 billion.

Overall, we found that the Baucus Amendment was meeting its objectives. It had encouraged state adoption of Medigap insurance regulatory programs at least as stringent as the federal standards, and only four states had not done so as of September 1986. This has resulted in more uniform regulation of Medigap insurance and increased protection for the elderly against substandard and overpriced policies.

Abuses still occur in the sale of Medigap policies. But many states have attempted to prevent abuse through such actions as monitoring sales and advertising practices and revoking or suspending insurance agent licenses and issuing cease and desist orders to insurers.

As mentioned above, the Baucus Amendment established standards for anticipated loss ratios; that is, the expected loss ratio had to be at least 60 percent for individual policies and 75 percent for group policies. The law does not require that actual loss ratios meet these requirements but only that the actuarially determined expected loss ratios do so.

¹Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies, GAO/HRD-87-8, October 17, 1986.

The actual loss ratios of most policies we obtained data on were below the Baucus Amendment targets. However, the loss ratios of the policies of most of the Blue Cross/Blue Shield plans and the Prudential Life Insurance Company were generally above the targets. These were the policies most commonly purchased. The Blue Cross/Blue Shield individual policies we reviewed had 1984 premiums of \$776.6 million and a weighted average loss ratio of 81.1 percent; the commercial individual policies included in our analysis had nationwide 1984 premiums of \$1.3 billion, and Prudential (with a 1984 loss ratio of 77.9 percent) had almost 25 percent of that business.

For the individual policies of commercial insurers studied, the weighted average loss ratio was about 60 percent for 1984. In other words, \$770 million in benefits were returned for the \$1.3 billion in premiums paid. Thus, for every \$1 in premiums, 60 cents was returned as claims payments or used to increase reserves, and 40 cents represented administrative and marketing costs and profits. The same figures for the Blue Cross/Blue Shield plans studied are 81 cents in benefits to 19 cents in costs and profits.

We recently obtained 1985 data (the latest available) to update our loss ratio data for some of the policies included in our review. We obtained data on 38 of the 394 commercial policies and 6 of the Blue Cross/Blue Shield policies. These policies represented over half (51 percent) of the 1984 earned premiums for all of the policies included in our review. The 1985 loss ratios were basically the same as those for 1984, generally changing by only 1 or 2 percent. Overall, the 38 commercial policies (total 1985 earned premiums of \$1 billion) had a weighted average loss ratio of 65.8 percent versus a 1984 ratio of 65.4 percent. The six Blue Cross/Blue Shield policies (total 1985 earned premiums of \$453 million) had a weighted average loss ratio of 88.6 percent versus a 1984 ratio of 86.5 percent.

Once again Prudential, the largest commercial Medigap insurer, had a relatively high loss ratio of 79.3 percent in 1985 (77.9 percent in 1984), while 63 percent (22 of 35) of the other policies had loss ratios below 60 percent. The Blue Cross/Blue Shield plans had loss ratios ranging from 80.8 percent to 122.0 percent in 1985.

Loss ratios need to be used carefully. State insurance regulatory officials told us that loss ratios are a useful tool in analyzing insurance policy performance, but caution that they are only a step in any analysis. Loss ratios must be interpreted with care because of the factors that may affect the computations. Early policy experience may result in a relatively low loss ratio because of waiting periods for certain conditions when the policy will not cover services. Also, new policyholders may be relatively healthy and file few claims, so a policy experiencing substantial amounts of new business may experience a relatively low loss ratio. Thus, loss ratios should be viewed over the time that represents "mature" experience. State officials could not give us a clear definition of mature experience, giving periods of 3, 4, or 5 years. Among the states we visited, Pennsylvania asks insurers to report annually their loss ratio data for the last 4 years, whereas Maryland requests data covering 5 years. A new reporting format recommended by the National Association of Insurance Commissioners requests data on 3 years' experience.

We obtained 3 years' loss ratio experience for 55 commercial policies during our review last year. The combined 1984 earned premiums for those policies was \$500 million, and the weighted average 3-year loss ratio was 60.5 percent. We

also obtained 3 years' loss ratio experience for 11 Blue Cross and Blue Shield policies. The combined 1984 earned premiums for those policies was \$572 million, and the weighted average 3-year loss ratio was 88 percent.

Medigap Is Not Catastrophic Insurance

As pointed out in our report, Medigap policies are not catastrophic insurance for acute or long-term care. They do not place a limit on policyholder out-of-pocket expenses and, in fact, can limit benefits for part B type services to \$5,000 per year, after which benefits for these services cease.

Medigap policies could be changed to become catastrophic acute care insurance. Insurers then could either (1) increase their premiums to cover the anticipated increase in benefit payouts or (2) choose to absorb all or part of the increase, thereby increasing their loss ratios. We do not know what, if any, proportion of the extra costs insurers would decide to absorb because this depends on their willingness to earn lower profits on this line of business. On the other hand, if there is a Medicare-administered catastrophic plan, the payouts on insurance for beneficiary out-of-pocket costs below the catastrophic threshold--that is, what Medigap insurance would become--would be lower than under current Medigap policies. Insurers could decrease premiums to reflect all or part of the decrease or use the lower payout to increase profits.

In addition, administrative costs for a Medicare-administered catastrophic program should be minimal, and benefit payouts should represent virtually all of such a program's costs. Regardless of differences in cost to beneficiaries, there should be several advantages for beneficiaries to a Medicare-administered catastrophic insurance plan over one administered by the private sector. First, Medicare would make such insurance universally available to Medicare beneficiaries. Commercial insurers, on the other hand, generally can pick who they insure and can choose not to insure individuals. Second, beneficiaries would only need to submit one claim. If administered by the private sector, presumably two claims would need to be submitted--one to Medicare and, after that claim was paid, another to the private insurer.

Finally, if a catastrophic acute-care insurance program for Medicare beneficiaries is established, there will probably continue to be a demand for Medigap-type policies. We believe that at least some portion of beneficiaries will still seek insurance against the out-of-pocket expenses they incur before the catastrophic limit is reached.

This concludes my remarks. I will be happy to answer any questions you may have.

Chairman STARK. Thank you very much.

You mention on page 6 picking and choosing. Do you have any evidence that the medigap insurance companies selectively market? And if so, what do they do to focus their advertising or discourage high-risk individuals? Does anybody know how they selectively market?

Mr. ZIMMERMAN. Mr. Dowdal, do you have any information on that issue?

Mr. DOWDAL. We did not specifically look at selective marketing during this review. I know that in the past, the House Aging Committee had a number of hearings related to that kind of issue, and that committee would have more information on that issue than we do.

Chairman STARK. But you feel it does exist.

Mr. DOWDAL. There is nothing to preclude them from doing selective marketing. And you know, if you are a wise insurance company, then I presume you would do it because they cannot have varying rates, depending on condition.

Chairman STARK. Mr. Daub.

Mr. DAUB. You chose your words very carefully with respect to whether the current medigap insurance market would be adversely affected by the offering of the President's proposal. Do you think the medigap insurance industry will lose some business because of the plan if it were enacted as it is proposed? Do the signs of statistical analysis indicate to you that that may be the case?

Mr. ZIMMERMAN. It is always a possibility when a consumer has a different choice to make. And I think the catastrophic acute proposal of Secretary Bowen or Chairman Stark will offer an alternative to people and they may choose to decide that with catastrophic coverage, either offered by the Government or through some other provision, they may not need the medigap coverage.

I think most insurance activities or decisions people make are personal decisions based on what they consider to be to their advantage. I think some people may decide that with catastrophic insurance providing a limit on their liability of \$1,000 or \$2,000, to go on their own and not get a medigap policy.

Of course, the medigap program could expand its coverage to make up for gaps that are existing in the system now if they should so desire.

Mr. DAUB. If in fact they would choose to do that, would they be hesitant relatively speaking, figuring that the government might just come in about 2 or 3 or 4 years later and offer expanded or longer term care and take that market away from them too?

Mr. ZIMMERMAN. That is always a possibility; 2 or 3 or 4 years is a relatively long time. I think if the Government decides to move and provide long-term care catastrophic coverage, I think it will probably be in some kind of incremental format. As the previous witness said and some of the comments made by the chairman, we are talking about what appears to be a very expensive proposition and I am not so sure the Government can leap right in right now and provide catastrophic long-term care coverage.

Mr. DAUB. Do you know what the price is of the Bowen plan in terms of the voluntary add-on premium for the proposal?

Mr. ZIMMERMAN. I think it is \$4.92 a month.

Mr. DAUB. That is what the administration claims is the cost. Do you know if in fact that has been verified, or if we have additional information from CBO or the Budget Office that says that it may cost more than that?

Mr. ZIMMERMAN. I have heard reports that it may cost more. I think a negligible amount more. I think it is in the neighborhood of maybe less than a dollar more a month in terms of increased premium cost.

Mr. DAUB. Well, now I want to use that for a minute, "negligible". Part B is three-fourths funded by general revenues, is it not?

Mr. ZIMMERMAN. That is correct.

Mr. DAUB. What would you think would happen to the baseline if we expanded the payment for currently covered services and charged a voluntary add on of \$4, \$5, \$6, \$8, \$10 a person? What would the tendency be to the three-fourths of the matching dollar, if you will, that comes out of the general revenue? Are we going to pull the costs of that add-on higher and higher disproportionately to those that may, in an inelastic/elastic argument, drop off of Medicare as we get to \$100 and \$200 and \$300 more for that premium in 1991 or 1992?

Mr. ZIMMERMAN. It is hard for me to see why it would increase that much between now and 1991 or 1992.

Mr. DAUB. You are adding a million people to the over 65 rolls now each year for the next 20 years.

Mr. ZIMMERMAN. Well, again I still find it difficult. We have got 30 or so million people on the rolls right now, so you are talking about basically a 3 percent or less increase a year.

There is no doubt that the part B premium is going to go up as it has over time.

Mr. DAUB. Part B contributions from general revenue costs us about \$30 billion now, right?

Mr. ZIMMERMAN. I think so.

Mr. DAUB. So 3 percent of \$30 billion is how much?

Mr. ZIMMERMAN. It is about a billion.

Mr. DAUB. About a billion. So it will at least add a billion more to the general revenue requirement to support that growth in part B. Would that not be correct?

Mr. ZIMMERMAN. That is correct.

Mr. DAUB. So you cannot ignore the part B cost while trying to figure out if the premium on the other side of this is going to take care of the payments just for the expanded coverage. There are two problems there, are there not?

Mr. ZIMMERMAN. Well, there are two—I would think those are two separate problems; one relating to how you fund a catastrophic add on versus the regular cost control issues in the regular Medicare part B program.

Mr. DAUB. And you do not think that one may affect the other as we sweeten up the kitty, if you will, on what the Government will pay for under part B.

Mr. ZIMMERMAN. I do not see where it is sweetening up the kitty. What you are doing is you are establishing a ceiling on the out-of-pocket costs of individuals. You are not covering additional services.

There could possibly be some diminution of the effect of out-of-pocket costs on increased services once you reach the catastrophic level, but that is a relatively—

Mr. DAUB. I think I am far afield. I think that is probably something that needs to be studied and get your estimate of rather than to ask you to speculate, and I recognize that.

I will call to your attention that I am going to be asking for some trend line studies after we are done with this whole thing this year to take a look at what I think will be an explosion.

Chairman STARK. Will the gentleman yield?

Mr. DAUB. We have already proved one point, then I will yield to the chairman, and that is that we put a program into effect and the taxpayers pay for it and then we sweeten it. We expand the dollars we pay for the definitions which then makes it even more of a Government program and even more expensive. So that fear exists. It is now coming to pass, I fear, and I worry about the next add on which may very well be simply to run the health care programs for a long term from the government point of view, as seems to be your suggestion in your testimony.

I would be happy to yield.

Chairman STARK. I think I follow you. Will there be a great deal of harm to the insurance companies? Let us see if I have these figures about right: the uncovered part of medical costs to the 30 million beneficiaries is about double; Medicare is only paying about half.

Mr. ZIMMERMAN. Fifty percent, yes.

Chairman STARK. So in round figures there is an \$80 billion somebody is paying for out there—charity, medigap, a whole host of things.

Medicare pays about \$20 billion of that, I am guessing, so there is about \$60 billion. Our bill will not cover but about \$2 billion, 3 of that, so it is not coming—so now my question is—

Mr. DAUB. Oh, I agree. It maybe now covers only 200,000 people out of 30 million.

Chairman STARK. Well, I know but there is still somewhere about a \$50 billion pot of risk for these insurance companies to go after.

Query to GAO. How much of that \$50 billion, if you follow my theory of coverage, is the insurance industry in the aggregate at risk? Could you guess?

Mr. DOWDAL. The out-of-pocket costs of the elderly now are mostly for services that are non-Medicare covered services and most of those are also not covered by medigap or other insurance.

Chairman STARK. I understand that. No, let us come back a minute.

Medicare is only covering half of these 30 million folks. The Federal Government, through Medicare, is spending about \$80 billion, Medicaid another 20. But there is another out-of-pocket cost to these folks of around \$60 billion, give or take \$10 billion let us say.

Of that \$60 billion, how much is being paid for by medigap or how much is the medigap industry at risk? If it is \$10 billion, what I would say to my friend from Nebraska is that there is still \$40 or \$50 billion exposure for the insurance companies to go after. If the insurance companies are covering \$40 of that \$50 billion, then we

may be hitting them. I do not know. Now that is what I am asking you.

Mr. DOWDAL. Covering somewhere around \$4 billion of that.

Chairman STARK. So there is still a whole host of opportunity for the insurance companies to be creative in providing risk coverage.

Mr. DOWDAL. Like, for example, very few policies cover the cost of prescription drugs for the elderly, which is a very substantial amount; several hundred dollars a year on the average.

Mr. DAUB. Yes, I think the chairman's approach here is an approach. And I think that if you measure courage in terms of the aggregate, one might argue that the President's proposal does not go far enough, because from a dollar's point of view—

Chairman STARK. I really do—

Mr. DAUB. I suspect you would, Mr. Chairman. And from a dollars and cents point of view is one way of measuring it.

I am rather more interested if we are going to end up spending \$10 billion not so much arguing over whether Bowen is an approach, or whether Stark-Gradison is an approach. I happen to like it better than I do the President's approach. But the fact of the matter is that if we are going to spend that much money I wonder if it is not a priority as to where it ought to go and under what mechanism—Government and/or private sector.

Chairman STARK. If you will sign on for 10, I will let you spend the first 5; how is that?

Mr. DAUB. Your program might just do that since your means test raises more money than you need to pay for what you want to do.

But I am interested in the point the chairman pursued. It is a very small amount of money is it not? If you take the amount that is not paid for by current programmatic activity under parts A and B of the range of total dollars paid for bills received by the consuming medical public over 65, it is a small amount of money.

Mr. ZIMMERMAN. Small but needed part. There is no doubt about it.

Mr. DAUB. Does it hit at the near-poor?

Mr. ZIMMERMAN. Excuse me?

Mr. DAUB. The middle income person or the—where does that \$4 billion go about?

Mr. ZIMMERMAN. Well, I think it goes across the whole spectrum. I mean there is no income tied to it. Actually a real poor person probably would be picked up by Medicaid.

Mr. DAUB. And completely taken care of.

Mr. ZIMMERMAN. But there is an awful lot out there that is still untouched. As Mr. Dowdal mentioned, you have the whole question of prescription drugs, very expensive. I think they are actuarially projectable for an insurance company. They can write policies dealing with that.

If you talk to most Medicare beneficiaries one of the first things they will tell you after they talk about how high the doctor's fees are, they will tell you about the drugs and how expensive they are.

Mr. DAUB. I think that is a big problem too, and I agree. I really appreciate the quick look you took at the subject you were assigned to examine. Thank you.

Chairman STARK. Mr. Pickle.

Mr. PICKLE. Well, Mr. Chairman, thank you.

I have looked over some of your comments. Let me ask you a couple questions.

On page 6 you say that medigap policies could be changed to catastrophic acute care insurance by increasing the premium or just absorbing the loss.

Are you recommending that catastrophic health insurance replace medigap?

Mr. ZIMMERMAN. No, sir, we are not.

Mr. PICKLE. Well, you say medigap could be changed.

Mr. ZIMMERMAN. That is right. The existing medigap policies could be changed to incorporate a catastrophic provision which in essence sets a limit on what a beneficiary would pay. It would be—relative to the cost of the average medigap policy—the cost would be small.

Mr. PICKLE. Well, you say it could be done, but they have not done it and they do not seem likely to do it.

Mr. ZIMMERMAN. Well, maybe the insurance industry would like to do it. I do not know.

Mr. PICKLE. I take it, though, that you are saying they could do that if they wanted to, but they do not do it. Therefore, you are indicating that we ought to establish a catastrophic insurance program because that will come near meeting the needs and requirements as we see them.

I just cannot help but believe that you are saying they could do all these things, but they do not so therefore we need to help—

Mr. ZIMMERMAN. They could have done it.

Mr. PICKLE [continuing]. Them provide it.

Do you recommend that we do away with the medigap program?

Mr. ZIMMERMAN. No, sir, I would not recommend that. As I pointed out in my statement, I think there is still going to be a market. People tend not to—

Mr. PICKLE. Well, I guess I am trying to clarify what you are saying. You do not say whether we should have medigap or we should not. You just say there would still be a medigap program.

Mr. ZIMMERMAN. That is correct, sir.

Mr. PICKLE. That is as far as you go on it.

Mr. ZIMMERMAN. The program was established basically in legislation 1980, we were asked to look at how well the standards that were set up are—

Mr. PICKLE. Let me ask, do you think there is a need for the medigap insurance program?

Mr. ZIMMERMAN. Is there a need? I think the millions of people that participate in it suggests to me that there is a need in their minds anyway.

Mr. DOWDAL. With the elderly, many of the elderly have a fear of going bankrupt because of having high medical expenses and medigap helps somewhat in covering those costs. If there were catastrophic, for example, say a \$2,000 limit, the exposure for Medicare services then would be \$2,000.

Some people would probably decide that, yes, I can handle \$2,000. Others would still want to have insurance protection for that and that is what we said would—if there were a catastrophic

insurance program, medigap in effect would become a \$2,000 policy or \$1,500 or whatever it was.

Mr. PICKLE. I am trying to determine if there is a place for the medigap insurance program, and at what level. If it is not working as it should, what is the proper level and how do we correct it. I am asking should we do away with it if we have catastrophic insurance coverage. You are saying no, if we have catastrophic you still need medigap, or there still would be a medigap program. If so, our problem is to determine at what level and how they would participate with whatever program we pass.

Mr. DOWDAL. Are you talking about improving on the Baucus standards for medigap insurance?

Mr. PICKLE. Well, I presume that the Federal standard is one of the positions you will advocate. You did that last year in testimony before our committee, did you not?

Mr. DAUB. Will the gentleman yield?

Mr. PICKLE. Yes.

Mr. DAUB. That is a very good point to raise. You were rather silent on any suggestion to improve the Baucus amendment. Was that on purpose?

Mr. DOWDAL. We looked at whether it was meeting the objectives that were set for it, which was—in loss ratios—60 percent anticipated loss ratio on individual policies, and we said basically it was meeting that objective.

Whether or not 60 percent is the right level, we did not address that. It is something that you—you know, personally I do not believe it is a very good deal to get 60 cents on the dollar and I would not buy it for myself if I knew that was what I was going to get.

But there are a lot of issues dealing with entry into the industry and how you project loss ratios and marketing costs and a lot of things like that that the insurance industry raised when the Baucus amendment was enacted. And at that time the Congress decided 60 percent was what they were going to put in.

Mr. DAUB. Have you done any studies on the Baucus amendment beyond this?

Mr. ZIMMERMAN. No.

Mr. DAUB. That is all. Thank you for yielding.

Mr. PICKLE. Well, I have an observation here. The chairman is correct, based on the GAO report, that Medicare pays out 98 cents on the dollar on health cost compared to only 60 cents in the medigap program. There is bound to be some reason for that great discrepancy. And if that discrepancy is in fact true, it would seem to me that we do need to look at the whole medigap program to see how it is administered, how much they pay out and if they are really giving sufficient coverage.

I would agree there will always be a medigap or some kind of program because individuals that are able to pay for it are going to have an extra cushion of protection; and we ought to encourage that.

So I am simply trying to determine what level and in what manner that protection should be offered, and I take it you do not make any recommendations. You are merely making observations.

Mr. ZIMMERMAN. Well, we are not making any recommendations related to what the medigap program should look like if cata-

strophic insurance is enacted. But I think it will have some effect on it. Presumably some people will decide not to continue with the medigap policies or the medigap insurers may decide to expand the coverage in some of the areas that Chairman Stark pointed out or suggested needed coverage.

Again, there is such a large amount of uninsured care out there that I think there is room for legitimate medigap market as well as having a federally——

Mr. PICKLE. Mr. Chairman, may I ask you, do we, the committee, have any investigation or study of the medigap program, how it is functioning and what services providers are giving for the premium they charge? Do we have a good evaluation of the entire medigap program?

Chairman STARK. Mr. Pickle, other than what the GAO has done in this study, no—it could very well come out of Energy and Commerce. And yet, I do not know what Senator Baucus' studies have shown. But I do not believe we have anything—the staff could correct me if I am wrong—other than what we have asked GAO to give us.

Mr. DAUB. I think there have been some studies on it, Mr. Chairman. There has been quite a thorough look taken at medigap over the last couple of years by a variety of committees of the Congress. As a matter of fact, according to testimony I have read, medigap policies have been improving and doing much better than they had in the past.

Mr. PICKLE. Well, let me follow through with one other question because I think it raises an interesting point.

Let us assume that we passed coverage for catastrophic illness along the general approach we are considering now. In that event could medigap policies begin picking up costs of long-term care if the catastrophic illness coverage bill is enacted?

Mr. ZIMMERMAN. They certainly could. They could expand their coverage to long-term care. They could expand their coverage to drugs.

Mr. PICKLE. If we were to pass a catastrophic illness coverage bill, would that provide a greater market for the sale of medigap policies that went into the long-term program?

Mr. ZIMMERMAN. I think they might not want to call it medigap. They may want to call it something else, because medigap is intended basically to deal with stuff that is covered under the Medicare program and it is a very narrowly focused area. And getting into a long-term care insurance and linking it up with medigap, I think might cause some confusion to the consumers.

Mr. PICKLE. Mr. Chairman, I suggest to the staff that perhaps we should get some kind of report from the proper source concerning how the medigap program is working. Will we hear such testimony at some point?

Chairman STARK. We will hear testimony today from both Consumers Union, the Health Insurance Association and Blue Cross on both sides of that issue, I am sure.

Mr. PICKLE. Thank you again.

Chairman STARK. Mr. Gregg.

Mr. GREGG. Following up on Mr. Pickle's comment, what sort of incentives could we generate to cause these companies to move into long-term care insurance?

Mr. ZIMMERMAN. I think a lot of the problem—they are wrestling with the problem themselves to try to figure out how to market it, how much it is going to cost and how to make money. There is not a whole lot of information on long-term care insurance out there, and people have to get more comfortable with it and do more studies and decide whether there is an opportunity to move in. And I understand they are doing that now.

I believe the insurance industry, if they feel there is an opportunity for them to provide good coverage and make some money at the same time, they are going to move in, and I think they are looking at long-term care now with that in mind.

Mr. GREGG. Have you done any—

Mr. ZIMMERMAN. But there are industry—excuse me. There are industry representatives here. I believe they are going to be talking this afternoon. They probably could tell you more about their latest strategy.

Mr. GREGG. Have you done any studies on long-term care which divides long-term care into catastrophic and non-catastrophic long-term care from a financial standpoint? In other words, what percentage of the people who receive long-term care end up spending more than—pick a figure, \$50,000, \$100,000, and thus are faced with catastrophic expenses?

Mr. DOWDAL. The best information I can think of on that relates to the number of nursing home patients who end up becoming Medicaid recipients, and that is over 60 percent. So that means that they have already expended all of their savings and spent—

Mr. GREGG. Do you know how much that average Medicare recipient spends down before getting to the point where he or she has to pick up Medicaid? What were the basic assets they went in with? Have you done that?

Mr. DOWDAL. I cannot recall. There are numbers on that. I cannot recall them offhand.

Mr. GREGG. Do you have them somewhere?

Mr. DOWDAL. I believe we have them in some reports that we have issued.

Mr. GREGG. Possibly you could send us a copy of that?

Mr. DOWDAL. Yes.

Mr. GREGG. Does this 40-percent profit figure that you talk about vary with the various parts of medigap that are being covered? In other words, do medigap insurer have a higher overhead and a higher profit margin when they are covering the acute functions of medigap versus just the entry level coverage?

Mr. ZIMMERMAN. I do not think that information is broken out, but let me check with Mr. Hultgren.

Mr. DOWDAL. No, the medigap policies have to cover a specific set of benefits, and some policies provide a little bit more than what the minimum requirements are. So basically these policies are pretty much all providing the same thing so there would not be—

Mr. GREGG. I am just wondering if—of the functions that they cover, are medigap insurers making more money on some of those functions than on others?

Mr. DOWDAL. There is no data available on that except directly from the insurance companies.

Mr. GREGG. Thank you.

Chairman STARK. Mr. Chandler.

Mr. CHANDLER. Thank you, Mr. Chairman.

If I could just make the same suggestion, the gentleman from Texas was asking some really relevant and some important questions and I would like to suggest that we pursue the questions that he raised.

Mr. ZIMMERMAN, a moment ago you said that the insurance companies as they look at—I think you were referring both to medigap, but also to long-term care insurance—that they had the problem of I wrote down how to market, but more importantly how to make money.

Now the committee, of course, does not worry about how to market. We will just make them take it. The insurance companies cannot do that. But we also, while we are not in this to make any money, we are going to be in it not to lose any.

What are the questions that those insurance companies are asking themselves that you were referring to? And why are they uncertain, and what questions does that raise for us that we ought to be looking at?

Mr. ZIMMERMAN. I was talking about the concept of catastrophic long-term care insurance. I think right now there is something like 70 insurance policies available and some 200,000 people who have long-term care insurance. Unfortunately, we are in the process of finalizing a report on long-term care insurance, and it will not be out for a few weeks. But I think, and I do not have it down to memory yet to relate to you all the problems that the insurance companies are concerned with.

But I guess it is a question of just being able to make decent actuarial forecasts of what you should charge in the way of a premium, at what point in somebody's life they should start paying that premium, and what the cost of care would be over time. If someone buys a long-term care insurance package at 21, presumably they may be paying for 50 years. If someone buys at 55 or 60, they may be paying over a much less period of time.

And then there is a question of how many people will actually sign up for long-term care insurance. Will you get the people to sign up that are sick now, that know they are going to need something? There are a lot of unknowns that need to be considered and studied.

And it is basically a new insurance market, and I think the insurance companies are going to have to spend more time with it until they get comfortable. But I do not think it is going to be cheap regardless of what they do.

Mr. CHANDLER. That would be no less true for insurance companies than it would be for us.

Mr. ZIMMERMAN. That is probably correct.

Mr. CHANDLER. Would logic tend to suggest that as the number of old people increases and their longevity increases—I have not

seen any projections for any stabilizing or at least reduction in health care costs—that all of those things are on an upward trend that it just absolutely follows that you are going to have to have an upward trend in premiums to cover those expenses.

Mr. DOWDAL. Basically that would be true, yes, because most of the long-term care policies that are currently out there now are indemnity policies—and most of them do not have a cost-of-living adjustment in them. So, they would not have quite as much problem if nursing home costs go up.

One other main issue is, I believe, that the insurance for long-term care is who is going to buy it. Since we have fairly good data from Medicare and Medicaid and from other studies of the total of number of people in nursing homes, what the chances are overall of people going into a nursing home are known. So, if you had everyone in the pool, then you would know what costs would be—if you knew you were going to have a representative sample of policyholders, then I would think it would be relatively easy to figure out a correct premium amount where you would not have to worry about getting run out of business.

But currently you do not know whether you are going to get that—

Mr. CHANDLER. The insurance company does not have that.

Mr. Chairman, could I ask you? Was there a study done on the Stark-Gradison proposal on the revenue side to determine its elasticity relative to level of benefits over the life of, say, 50, 30, 20, 10 years?

Chairman STARK. Elasticity in what?

Mr. CHANDLER. Just to cover the expense without adjustment by the Congress of—

Chairman STARK. Well, all we have is a 5-year estimate from the joint tax—you mean as to the revenue coming in from the income tax side?

Mr. CHANDLER. Do we know what the line is for benefit increase? Do we know what the line is for—

Chairman STARK. No, that balances out. As the benefit goes up, the actuarial value goes up, the tax goes up. So, it parallels.

Mr. CHANDLER. And they parallel. That is the—

Chairman STARK. Yes, that is the way it was designed—I would hope. The idea was that the value of the benefit gets included into your tax unless we drastically change the tax rates. But then one would presume that we could adjust that if we wanted to. But based on a constant tax rate, I think it is self-liquidating. That is what I would hope.

And the revenue estimates we have were done by joint tax in terms of our estimate of the actuarial value. Now, those things, if they change, should be linear. I do not know that they are, but that would be my guess. If they are not, you have just exceeded my knowledge of the whole topic.

Mr. CHANDLER. I did not mean to embarrass you.

Chairman STARK. That is always a sure shot to embarrass me.

Mr. CHANDLER. Thank you, Mr. Chairman.

Chairman STARK. Mr. Levin?

Mr. LEVIN. Thank you for sharing your earlier testimony. I am jumping back and forth between subcommittees.

I do not know if you have covered this. On page 2 you talk about abuses and that many States have attempted to prevent abuse through such actions as monitoring sales and advertising practices.

Were you able to discern the level of effective information received by prospective purchasers? Is this a problem in your estimation?

Mr. ZIMMERMAN. Well, I think it is a problem. I am going to have Mr. Hultgren respond since he worked directly on it.

Mr. HULTGREN. Your question, sir, is what did we find the level of information available to prospective policyholders to be?

Mr. LEVIN. Adequate. Do most people really know what they are buying when they buy medigap policies?

Mr. HULTGREN. That is a difficult question to answer, whether or not they really understand what they have bought. There is a fair amount of descriptive information that a prospective policyholder must be given when he is approached by a sales agent. That includes an outline of benefits that describes to the prospective policy purchaser what Medicare will cover, what he is liable for, and what the policy covers. And that was required through the Baucus amendment legislation.

Mr. LEVIN. Were able to determine if it is being effectively implemented, in your judgment?

Mr. DOWDAL. What we basically concluded was that the state and Federal Government have done a pretty good job of making information available to the elderly so that they can make a better decision on whether or not and which type of medigap insurance to buy. But it is still a very complicated decision. You know, no matter how much information you give someone, it is how they use it. So, it is difficult to say that they—you know, we cannot guarantee that somebody will make a right decision.

Now, Maryland and some other States have put together a pamphlet for their State senior citizens which also lists besides the benefits the premiums in it. So, that gives seniors some additional information. In most States that type of information is not available, but in a number of States it is. So, then seniors can also judge based on the benefits what the premium is going to be, which gives them another piece of information which would assist them.

Normally the loss ratio data is not available when they make a decision.

Mr. LEVIN. So, were you able to reach a bottom line conclusion that the vast majority of people know what they are buying?

Mr. DOWDAL. No. We were able to determine that the information made available to the elderly, when they are making this decision, is pretty good information for them to use. Whether they actually understand what all of it means, you know, you would have to ask each individual person that.

Mr. LEVIN. Mr. Chairman, you were shaking your head.

Chairman STARK. I'm in agreement with what he is saying. I am sorry if it looked like a no.

There is a fair amount of effort on the part of the States and HHS to get information out to the consumer. The problem you are faced with is complexity. If you have a copy of our report, on page 20 we list the benefits covered by medigap. I think that even the best educated consumer in the world is going to have a hard time

making a judgment trying to figure out what he is buying or what he is getting, and trying to understand the terminology and the language.

Mr. LEVIN. So, I am more confused. You seem to be saying that, therefore, lots of people will not really know what they are buying.

Chairman STARK. I am saying it is hard to understand. But again, sometimes people surprise me at what they can understand and what they cannot. But I think by and large it is a difficult decision. It is not an easy decision for people to make. The information is made available to them. How well they are able to deal with the information and understand it, is difficult for me to say.

I believe some studies have been conducted by the insurers themselves in an attempt to find out to what degree people are comfortable with the policies and understanding them. But there is still some doubt in my mind as to whether people in this group fully comprehend the ramifications and exactly what they have purchased.

Mr. DOWDAL. Basically, we concluded that compared to what senior citizens used to have available to them, it is a hundred times better because they used to have virtually nothing available. Now, at least there are some sources of information that they can use when they are trying to make a decision related to medigap insurance.

Mr. DAUB. Will the gentleman yield?

Mr. LEVIN. Sure.

Mr. DAUB. I have found just in my own district over the last 6 years as I have watched this issue, first as a member of health and long-term care on the aging committee, that your aging office network and a lot of the other networks we have do provide needed information to Medicare beneficiaries. Additionally, in Omaha, we have New Horizons, a senior citizens newspaper that comes out every month.

The Baucus amendment and the reports you have done previously indicate, as Mr. Dowdal said, a substantial improvement in the availability of and I think the understanding by seniors of their health care requirements and their options. The Baucus amendment is probably not perfect, but I do think that these folks and others have made a very diligent effort to be sure that it is being paid attention to by the insurance industry.

Mr. LEVIN. Thank you.

Chairman STARK. Thank you, gentleman.

I thank the panel very much and we appreciate your testimony and look forward to working with you as we continue to work on this legislation.

Our next witness is Linda Lipsen, who is the legislative counsel for the Consumers Union. Ms. Lipsen is here to tell us about some gaps in the medigap and perhaps some of the problems that they have found.

Your complete testimony will appear in the record, and you may wish to summarize it or expand on it. Please proceed.

STATEMENT OF LINDA LIPSEN, LEGISLATIVE COUNSEL FOR THE CONSUMERS UNION

Ms. LIPSEN. Thank you very much, Mr. Chairman.

Members of the Health Subcommittee, I am Linda Lipsen, the legislative counsel for Consumers Union, the publisher of Consumer Reports magazine.

We greatly appreciate this opportunity to come before you to discuss our views on catastrophic health insurance and the medigap or Medicare supplemental insurance market.

We are extremely encouraged that Congress will take steps to improve the Medicare program for the Nation's elderly. While making necessary improvements in Medicare, we urge this committee not to lose sight of the crisis in health care access for the 37 million nonelderly Americans without any health insurance whatsoever.

As you review the various proposals to augment Medicare, we urge you not to hesitate in supplanting the private market with expanded Federal coverage. Medicare is not only more efficient than medigap, but it can deliver more value for consumers' money.

Medigap policies tend to be high cost, low value policies. Premiums range from \$150 to \$1,500 per year. The cost of marketing, administration and profits consume 40 percent of the premiums collected. By way of comparison, Medicare's administrative costs are three percent of revenues.

Consumers Union has always valued highly the benefits that healthy private markets can bring to consumers: low prices, high quality and product innovation. While we often make suggestions to federal agencies about improving regulations to increase safety, or about enforcing antitrust laws, we do not rush to conclusions that private markets are not fixable and should be replaced by an expanded government. However, the abysmal track record of medigap in its failure to serve consumers adequately compels the conclusion that a governmental solution is justified.

The House Subcommittee on Health and Long-Term Care last year estimated that older Americans waste \$3 billion annually on medigap policies because of duplicative health insurance policies and low loss ratios. Loss ratios, as the gentleman from the GAO explained, are the percentage of premiums collected that are paid in benefits.

Through the years abuses in the Medicare supplement insurance market have been exposed by this committee, by the House and Senate Select Committee on Aging, by the Federal Trade Commission, by several State insurance departments. With the advent of medigap, came the recognition of abuses in its sales.

In 1980 Congress passed the Baucus amendment which established minimum standards and target loss ratios for the medigap market to be implemented by the States. Notwithstanding this initiative, GAO reported recently that loss ratios of most commercial policies fell below the 60 percent target.

The report found that States were not monitoring actual loss ratios of the companies, but rather accepting the companies' expected or anticipated loss ratio to determine that sufficient benefits are being paid out to consumers.

Many Medicare eligible continue to be sold overlapping duplicative policies. Our San Francisco office has identified a 79-year-old woman with five overlapping medigap policies, three nursing home policies and one hospital indemnity policy amounting to \$6,500 per year in premiums. Other couples were found to have \$10,000 and \$13,000 worth of overlapping medigap policies. This is not an unusual or an anomalous tale.

The level of understanding as to what Medicare and medigap will cover or what they will not cover continues to be very low. For example, 70 percent of the population over 65 believes that Medicare will cover long-term nursing home stays. And half of those with medigap policies believe they are covered for long-term care expenses.

Consumers are confused and for a very good reason. Medicare with its parts A and B, coinsurance, deductibles, skilled nursing facilities, intermediate care facilities, benefit periods, lifetime reserve days, physician assignments, et cetera is an impossible maze which defeats even the most educated consumer.

Adding to this confusion, consumers must comprehend a variety of private policies marketed to the elderly often through deceptive marketing techniques. Throughout the Nation seniors have been sent mailings that appear to be official Government notices of cuts in Medicare benefits. In fact, the mailings are from insurance companies and firms which develop and sell these to insurance agents. There are many other tactics that agents and insurance companies have used.

We are certainly not saying that the medigap insurance market is run by thieves, but there are certainly some companies that are not delivering very good value for the money that consumers pay.

We recognize that a catastrophic insurance program of the type proposed by Chairman Stark or Secretary Bowen would displace a portion of medigap policies and would force many medigap policies to restructure their benefits. We welcome this shift because we believe that an expanded Medicare can serve consumers far better than the private medigap market.

Thank you.

[Statement of Ms. Lipsen follows:]

STATEMENT OF LINDA LIPSEN, LEGISLATIVE COUNSEL, CONSUMERS UNION

Mr. Chairman and members of the Subcommittee on Health, Consumers Union* appreciates the opportunity to present our views on the issue of catastrophic health insurance coverage under the Medicare program. We commend Chairman Stark for his longstanding interest in increasing access to quality health care for all Americans. We value his thoughtful leadership on the issue of catastrophic illness insurance under Medicare.

This testimony will discuss the failings of the private medigap market and the inappropriateness of relying on it for catastrophic and long-term care coverage.

By way of introduction, we would like to note that Consumers Union -- publisher of Consumer Reports -- values highly the benefits that healthy private markets can bring to consumers: low prices, high quality, product innovation, to name just a few. Consumer Reports provides comparative product information with the goal of helping consumers function more knowledgeably when they purchase goods in the private market. This month's magazine, for example, rates (among other things) color TV's, several cars, soups, and steam irons. While Consumers Union often makes suggestions to federal agencies about improving regulations to increase safety or about enforcing antitrust laws, we do not rush to conclusions that private markets are not "fixable" and should be replaced by an expanded government.

With this as background, the main point we would like to make in this testimony is that the private medicare supplement insurance market has failed. Despite numerous attempts by the federal and state government to improve its performance, the "medigap" market is wasting consumers' limited health care dollars. The House Subcommittee on Health and Long-Term Care estimated last year that older Americans waste \$3 billion annually because of duplicative health insurance policies and low loss ratios. [Catastrophic Health Insurance: The Medigap Crisis, Hearing before the Subcommittee on Health and Long-term Care of the Select Committee on Aging, House of Representatives, June 25, 1986, p. 146] Because the private medigap market has performed so poorly, Congress should not hesitate to displace it when expanding Medicare's coverage of catastrophic expenses. In addition, Congress should not allow the emerging market for long-term care insurance to follow the medigap market's uninspiring model.

The acute and long-term health care needs of the elderly deserve immediate Congressional attention. However, we do want to point out that health financing problems faced by people under 65 are also severe and need to be addressed. 37 million people in our nation face limited access to health care because they do not have health insurance. Nearly 12 million of the uninsured are children. Between one quarter and one third of Americans are underinsured, and face the risk that out-of-pocket

*Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide information, education and counsel about consumer goods and services and the management of family income. Consumers Union's income is derived solely from the sale of Consumer Reports, its other publications and films. Expenses of occasional public service efforts may be met, in part, by nonrestrictive, noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, Consumer Reports, with approximately 3.5 million paid circulation, regularly carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

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medical expenses will consume a large percentage of their income. [Margaret B. Sulvetta and Katherine Swartz, The Uninsured and Uncompensated Care, National Health Policy Forum, June 1986, p. 19] Inadequate access to health care at a reasonable cost is a major barrier to escaping poverty. Many working families live on the edge of poverty or actually fall into it because they experience high, unreimbursed health care costs. Many working people with incomes far above the poverty level are uninsured; 35% of the uninsured have incomes greater than twice the poverty level. Mr. Chairman, we urge you to continue your efforts to increase insurance coverage for all Americans.

Poor Performance of the Medigap Market

The consistent failure of the medigap market to meet the needs of health care consumers clearly justifies an expanded role for the federal government in establishing catastrophic illness and long-term care protection. In the late 1970's, abuses in the medicare supplement insurance market were exposed by the House and Senate Select Committees on Aging, by the Federal Trade Commission, and by several state insurance departments. In addition to marketing abuses such as "loading up" (selling multiple overlapping policies to vulnerable consumers), "twisting" (convincing a client to switch policies, thereby increasing exclusions for pre-existing conditions), "clean sheeting" (where agents ignore applicant's health problems on the application form, but leave the client vulnerable to having claims rejected later), the Federal Trade Commission found that medicare supplement policies very often had very low loss ratios (percentage of premiums collected that are paid in benefits). Moreover, it was revealed that people eligible for medicare supplement insurance policies were understandably confused about how to evaluate the available policies; and very little information about the worth of the policies existed.

In response to the documented abuses within the medigap market, the Congress passed the "Baucus Amendment" in 1980, adding section 1882 to the Social Security Act. State insurance departments have also attempted to regulate this market, though with varying degrees of enthusiasm. Despite these efforts from federal and state governments, the problems still persist. The General Accounting Office recently reported that while the market has improved somewhat, loss ratios of most commercial policies were below the targets enunciated in the Baucus Amendment and averaged 60.2% in 1984. [Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies, General Accounting Office Report to the Subcommittee on Health, Committee on Ways and Means, October 1986, p. 4] In addition, the report found that most states do not monitor the actual loss ratio experience [GAO Report, p. 25].

Consumers Union continues to find abuses in this marketplace. On October 14, 1986, the San Francisco office of Consumers Union (joined by eight other organizations) filed a petition before the California Commissioner of Insurance to halt the unfair and deceptive marketing of medigap insurance to senior citizens. The petition claimed that unscrupulous agents in California had:

- (1) loaded up senior citizens with overlapping policies;
- (2) caused seniors to cancel policies and replace them with new ones creating lags in coverage;
- (3) misrepresented themselves as being from government agencies or independent senior organizations; and
- (4) exaggerated the coverage offered by policies and failed to disclose the substantial limits and exceptions to coverage.

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State insurance commissions, the Department of Health and Human Services, and Consumer Reports (in a June 1984 article rating medigap policies) have attempted to educate consumers about medigap policies and their limits. But despite these efforts, consumers continue to be uninformed and purchase duplicative and low value policies. Consumers are confused, and for good reason. Medicare -- with its Parts A and B, coinsurance, deductibles, skilled nursing facilities, intermediate care facilities, benefit periods, lifetime reserve days, physician assignment, etc. -- is an impossible maze, defeating even the most educated consumers. It is no wonder that 70 percent of the elderly believe that Medicare would pay for long-term nursing home care. Adding to this confusion, consumers must comprehend a variety of private policies marketed to the elderly (often through deceptive marketing techniques)-- medigap policies, hospital indemnity policies, dread disease coverage. It should come as no surprise that research shows that the level of knowledge the elderly have about Medicare and private insurance is extremely low. [Nelda McCall, Thomas Rice, and Judith Sangl, "Consumer Knowledge of Medicare and Supplemental Health Insurance Benefits," Health Services Research, February 1986, pp. 633 - 657] Based on the medigap market's overall performance record, there is no justification to rely on it for catastrophic or long-term care insurance.

Catastrophic Protection within Medicare

Consumers Union strongly supports the concept of restructuring Medicare to provide the elderly with protection against catastrophic illness. Both Chairman Stark's and Secretary Bowen's proposals regarding catastrophic expenses of the elderly would greatly benefit those individuals with the most severe medical expenses. With Medicare paying less than one half of the health care costs of the elderly, there is clearly a compelling need for this protection. The cost of catastrophic illness on the elderly often imposes a serious financial burden. Data contained in Secretary Bowen's Report indicate that 10% of the elderly have out-of-pocket health care liabilities of \$1000 or more a year. [Bowen Report, p. 26] Additionally, this financial burden does not fall according to ability to pay. Expected out-of-pocket expenditures represent a much larger percent of income for low-income consumers than of higher income consumers. [Changing the Structure of Medicare Benefits: Issues and Options, Congressional Budget Office, March, 1983]

We recognize that a catastrophic insurance program of the type proposed by Chairman Stark or Secretary Bowen would displace a portion of medigap policies and would force many medigap policies to restructure their benefits. We welcome this shift to the public sector, because we believe that an expanded Medicare can serve consumers far better than the private medigap market. Medicare's administrative costs are 3% [The Medicare and Medicaid Data Book, Health Care Financing Administration, 1983, pp. 69,70], while administrative costs, marketing costs and retained proceeds for commercial medigap policies average about 40%. The private market has tried, and has been given more than enough time to rise to the challenge of serving consumers. But after years of abuses and ineffective regulation, we believe it is time to try another approach.

Most proposals for catastrophic illness protection continue to leave a sizable market left unfilled. We urge you to consider ways to ensure that the newly designed gaps in Medicare do not lead to yet another round of victimization of consumers. There are several options worth considering. The first option is a Medicare-sponsored voluntary policy which would cover the \$2000 (or \$1500) out-of-pocket cost-sharing

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expenses. This policy might also include (as an option the consumer could elect) coverage for prescription drugs and other types of costs not presently covered by Medicare. An expanded Medicare would save substantial marketing and administrative costs and deliver more health benefits per dollar to consumers. Further, a public sponsored program could alleviate the labyrinthian search process for high value, comprehensive coverage.

A second option is for Congress (or its designee) to design a standard medigap policy; the Department of Health and Human Services could be asked to select a private company to market and administer this policy, under a competitive bidding process. This would enable the private market to continue to play a role in serving this market.

A third option is to drastically upgrade the so-called Baucus amendment to require DHHS and/or the state insurance departments to enforce a genuine minimum loss ratio. The industry portrays the sense that the Baucus amendment established a minimum loss ratio of 60% for individual medigap policies. In fact, the Baucus Amendment only sets a target; few states even bother to monitor the actual loss ratio experience. It comes therefore as no surprise that most commercial policies have loss ratios lower than 60% (and many of these are far below 60%). If this option were adopted, we would urge the Congress to increase the minimum loss ratio sufficiently to drive out the poorly performing companies.

We hesitate to strongly recommend this third option because we are not confident that most regulators have the resources or the will to correct the abuses that have occurred for twenty years and will undoubtedly continue to exist. Even a high minimum loss ratio, effectively enforced, would not eliminate incentives for agents to sell numerous, duplicative medigap policies and dread disease and hospital indemnity policies which are not covered by the Baucus Amendment.

Further Options for Long-Term Care Protection

Secretary Bowen's recommendations with regard to long-term care stress public education, tax benefits for personal savings, and tax subsidies to encourage the purchase of private insurance. We urge you to consider additional options. We fear that the private market will do no better with regard to long-term care than it has done with regard to medicare supplement insurance. Two options that we believe warrant consideration are first, a voluntary Medicare Part C to cover long-term care needs, financed in part by a premium paid by participants and in part by cost-sharing, and second, an expanded Medicare to cover long-term care expenses for all participants.

A voluntary Medicare Part C covering costs of long-term care has several advantages over private market coverage. They include: (1) lower administrative and marketing costs; (2) greater value for money for consumers because loss ratios would be much higher than equivalent private policies; (3) reduced consumer search costs and confusion resulting from inadequate information about the worth of products in the private market; (4) increased access for all of the Medicare-eligible population to long-term care coverage because no applicants would be turned down due to poor health. (In contrast, the private market would not be able to accommodate applicants that they believe are poor risks).

The second option that should be considered is expanding Medicare to cover long-term expenses for all participants. The key drawback to this option is the significant amount of new federal dollars that would be needed to finance it. (A good portion of the expense would be a shift from Medicaid spending to Medicare spending.) Through gradual phase-in of benefits and significant cost-sharing (possibly a portion of social security

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checks of those using long-term care services), the impact on the federal budget could be reduced. A proposal along these lines has been developed by the Harvard Medicare Project in Medicare: Coming of Age -- A Proposal for Reform [Harvard University, 1986].

Mr. Chairman, we appreciate the opportunity you have afforded Consumers Union to present its views on catastrophic health coverage under Medicare, and look forward to working with you on this important issue.

Chairman STARK. Thank you.

We have heard that the proposals before this committee, whether it is the President's proposal, Dr. Bowen's or Mr. Gradison's and my proposal, will not help very many people. But you have indicated in your testimony—and I think the words are: "that these would greatly benefit some people."

Which type of beneficiary do you think would benefit most from the proposal that this committee is now considering?

Ms. LIPSEN. The Bowen proposal and your proposal?

Chairman STARK. The benefits are relatively similar there.

Ms. LIPSEN. Well, we see an expansion. We do see an expansion in the benefit package. We like the lower cap that you provide in your proposal more than the \$2,000 cap. But we are still evaluating both of these proposals. We agree with the intents of these proposals that to expand the Medicare coverage for catastrophic insurance. And at this point we have not gone through the details—as to which program would better serve consumers.

Chairman STARK. Well, I was not asking you to pick between them. I am just saying their benefits are somewhat similar.

Ms. LIPSEN. Right.

Chairman STARK. It has been suggested that it is not doing very much for very many people. Can you comment on what group of people you think would benefit from the least generous of the two proposals, and why you think this might be important for us to proceed with?

Ms. LIPSEN. Well, the people that are going to benefit are the people that can afford to pay \$2,000 out of pocket or the people that can afford to pay \$1,500 out of pocket. Those are the people that are going to benefit.

The people that are not going to benefit and continually have not benefited under the Medicare program are the people that need more services. They need dental services. They need pharmaceutical services. And those are people that are still going to be left out under this program.

Also, certainly the long-term care element is a critical element that needs to be considered by this committee. But we are looking at the glass as half full instead of half empty.

We were very heartened to hear the chairman's discussion of this last week. And we understand that the committee will be entertaining other proposals to do something about long-term care either in this Congress or the Congress that will follow.

Chairman STARK. Mr. Gregg?

Mr. GREGG. Which would you rather see as a way to pay for this, a premium or the Gradison and Stark approach?

Ms. LIPSEN. If you could add to the Medicaid roles, our preference would probably be premium paid. But, if that is not on the table, we see the benefits of establishing a program in which the people that can afford to pay will pay for the benefit.

We are a little bit concerned though with the numbers that 35 percent of the elderly I believe under your program will have to pay for the other 65 percent. And we think that might place an overwhelming burden on some.

So, I guess my answer is twofold. We would like to see some expansion of Medicaid to include more of the poor within that pool,

but we can also see the benefits of doing something on—that creates payments based on ability to pay.

Chairman STARK. Would the gentleman yield at that point?

Mr. GREGG. Certainly.

Chairman STARK. It has been estimated—this is ball park—that the savings to the Medicaid system under probably either proposal, would be large enough to allow Medicaid to pick up most of the \$1,500 to \$2,000 for all people living below the poverty level. And I gather that is \$7,500 and \$10,000 for a couple now.

If we had that extra money, do you think that would be a high priority or just a so-so benefit? Or can you see other areas that might be more critical?

Ms. LIPSEN. No. We would see that as being very beneficial and we would urge the committee to consider it. Definitely.

Mr. GREGG. I have no further questions.

Chairman STARK. Mr. Pickle?

Mr. PICKLE. Mr. Chairman, thank you.

In your testimony you point out, based on your study, that medigap has not fulfilled its claims, and that the public had been confused and misinformed, if not cheated in some cases. You are quite critical of medigap based on the studies that you had.

Now, on the other hand, you say that Medicare is a failure, that it is a hopeless, impossible maze. You listed all the complexities of part A and B and coinsurance and six or eight other things.

So, it seems to me you are against medigap and Medicare, and that you want to set up a new policy that is going to settle the whole thing. Is that an oversimplification?

Ms. LIPSEN. We have never asserted that Medicare is a failure. All we are saying that there is a lot of misunderstanding out there as to what Medicare will or will not cover.

Mr. PICKLE. I think I heard you say it was a hopeless maze.

Ms. LIPSEN. We would certainly—

Mr. PICKLE. And you listed all the reasons why it is a hopeless maze, and you make a pretty forceful case.

Ms. LIPSEN. We would certainly encourage this committee to adopt simplification—some kind of a simplification procedures of Medicare.

Mr. PICKLE. If you say it is an impossible maze, that is a pretty strong condemnation of it. But, we cannot be against both. We have to find an answer. And the easiest thing is to say that we have got to make some change and turn to the public sector.

I assume you want expanded coverage of the Medicare program. I was just trying to list what you are recommending, and I notice you start off by advocating a volunteer policy have optional prescription drugs. I am trying to go through your testimony because you have not told us what you recommend.

Ms. LIPSEN. I was told I only had 5 minutes.

Mr. PICKLE. Well, I think it would be important and I would ask you, what would you recommend?

Ms. LIPSEN. Well, we would like to see another—a voluntary option to cover prescription drugs and that would also cover physicians the excesses that Medicare will not cover and all the uncovered expenses that compose a great deal of burden, dollar burden, on elderly consumers. We would like to see that.

We would like the committee to look into whether or not some kind of a mandatory option of long-term care is feasible because we are concerned that the private market will not be able to respond to the long-term care needs because of adverse selection. The people that would want long-term care insurance coverage would be at risk and providing such coverage might not be profitable for the company.

Mr. PICKLE. Does your testimony cover the recommendation of how you would do it, what kind of program you would recommend?

Ms. LIPSEN. The testimony does not go into it in great detail.

Mr. PICKLE. Let me ask that you submit that to the committee because——

Ms. LIPSEN. I certainly would.

Mr. PICKLE [continuing]. None of us has the answer. It is not enough for our committee to have you say that Medicare has been a dismal failure or a hopeless mess, and that medigap is not working either. I would like to have your suggestion. We would hope that you would submit it to us because we are entitled to know what you recommend. So, I would be glad to have your recommendation.

Thank you, Mr. Chairman.

Chairman STARK. Thank you.

Mr. Chandler?

Mr. CHANDLER. Thank you, Mr. Chairman.

I would like to ask you to expand, if you could, on your comments about the funding. You said that the Stark-Gradison proposal was wanting and that it tends to rely on a smaller group of people which clearly it does. And there is a reason for that.

What is your idea for funding? What is the fairest way to fund?

Ms. LIPSEN. We would like to see some mixture between premiums and taxing actuarial value. We think that those two approaches can be put together. Now, we have not worked out the details, and Representative Pickle has urged us to be more specific. And we will be providing that to the committee.

Mr. CHANDLER. I would like to urge that too.

Now, on the benefits side, I think the same question has to be asked. I am asking myself—and I think the committee is too—do we provide the same level of benefits to every participant regardless of income. What was your answer to that? Or have you addressed it?

Ms. LIPSEN. We have not addressed it as an organization. So, I would be unwilling at this time to make any suggestions relating to that.

Mr. CHANDLER. Do you agree that you could enhance benefits for those who were recipients if there were restrictions, say, some kind of a floor level depending on income above which you would provide benefits? There is a term, and I cannot think of it. Once you have spent up to a certain level, if you have income that allows you to do that, then our so-called catastrophic would kick in. Have you examined that?

Ms. LIPSEN. We have not, but we will.

Mr. CHANDLER. And I am just curious. I know that we take the magazine. Who is the Consumers Union?

Ms. LIPSEN. We are the organization that puts out the magazine, but we have advocacy offices in California, in Texas and in Washington, DC.

Mr. CHANDLER. Do you ask for our opinion as subscribers and then represent that here? Is that what—

Ms. LIPSEN. We are getting it now.

Mr. CHANDLER. No. I do not mean that. I am just curious of who you speak for.

Ms. LIPSEN. Well, we do speak for many of our subscribers. Often if they do not agree with the positions that we take on particular issues that are delineated in the magazine—and we have covered medigap for years and also the Medicare program for years. If they do not agree to it, sadly enough the private market works. They cancel their subscription.

Mr. CHANDLER. Just one final question. When you were saying that the public sector works better in the medigap area, I kind of wonder if you would not concede that you really are comparing apples and oranges. The GAO representatives indicated that it was relatively easier when you require everybody to participate as opposed to figuring out who is going to be insured, how many of them are going to sign up, and marketing to them, and so forth. So, while it is certainly valid to compare publicly and privately provided benefits it is an unfair comparison to say one performs better than the other without taking into consideration those facts.

Ms. LIPSEN. Yes. It is hard to compare although the consumers that we have talked to all over the country—and we have petitioned the Department of Insurance in California to urge the companies to halt their deceptive marketing practices, the overwhelming majority say that they feel much more comfortable in the Medicare portion of their benefits than asserting other claims through the medigap market.

Mr. CHANDLER. Yes. I want to make it clear for the record, I am not referring to any deception or anything like that. It is just simply taken as a benefit and something that has to be paid for that you really cannot compare the publicly provided benefit with the private one.

Mr. CHANDLER. Thank you, Mr. Chairman.

Chairman STARK. Mr. Daub.

Mr. DAUB. You are not saying that really the Government really ought to run this whole business, are you?

Ms. LIPSEN. We would prefer, yes. We would certainly prefer, based on years of looking at this market, we would prefer the Government to run this program.

Now we could also see another option of getting—I mean there are certain companies that produce very well in the medigap market. I think the GAO mentioned today that Prudential has produced valuable policies, writes very valuable policies for consumers, and Blue Cross/Blue Shield has had great successes in this area.

Could there be a mechanism by which the Government could take competitive bids from the private sector and supervise or sponsor the program with a private company providing the coverage.

Mr. DAUB. Is there a difference between whether someone can read and understand and be thoroughly conversant with the purchase of their homeowner's policy or their automobile policy and whether people over 65 can comprehend their health policy?

Ms. LIPSEN. Well, I think the fears are different. When you reach that age, in the over 65 age group, you are subjected to fears about the financial costs of a long-term illness, et cetera.

Mr. DAUB. We do not want to be concerned about their shelter and their other needs after age 65 near as much as we do want to be concerned about their health care needs.

Ms. LIPSEN. Well, certainly shelter is a very important concern for the elderly as well.

Mr. DAUB. The Government is not telling us, or telling older Americans what they ought to be doing about their home and their homeowner's policy or their car. Many more are driving now and using automobiles past age 65 as well.

Does it have something to do with illness, or something to do with just being old?

Ms. LIPSEN. I think it is——

Mr. DAUB. From a consumer point of view.

Ms. LIPSEN. I think it is the uncertainty when you get to health care. I mean you have no idea how many dollars you are going to have to pay out. You have no idea whether or not you are going to have to impoverish yourself or your spouse, to get any kind of health care benefits at all.

Mr. DAUB. So your group would support a fully funded Government program for everyone—I assume for long-term health care, prescription drugs, and nursing homes.

Ms. LIPSEN. The private market has had a long time to become involved in the long-term care area, and in providing prescription drugs through insurance. All we can say is over the course of many years the private market has not been very involved in this area. So obviously——

Mr. DAUB. Maybe you put your finger on the reason though. That uncertainty about the cost and the inability to have a fund where the claims against it will not cause such early massive underwriting losses that that life care policy offered by a company might not be there because it went broke in 3 years.

Ms. LIPSEN. No. We see that there are some, certainly there is some adverse selection going on, that these policies might not be profitable. So the only other alternative that we can see is to have the Government get more involved in this because the private market is not doing it.

Mr. DAUB. Well, I appreciate your testimony. I guess I take the other point of view that if we do not interfere with what is currently becoming profitable relative to medigap insurance, and if we quit signaling the ominous signs of the 1970s, now that we have started to improve the management of that private/public partnership, we might encourage these insurance companies to get into the long term, not ill or sick, but life care. Maybe the Government needs to do what it did several decades ago relative to Kerr-Mills—open up the group markets in the work place not just for retirement benefits, but for health care benefits too, and make them tax advantaged.

Chairman STARK. Ms. Lipsen, can you just quickly run through the other organizations that are coplaintiffs in your lawsuit in California?

Ms. LIPSEN. I do not—I did not come up here with a list. We have several elderly groups that have been involved, organizations.

Chairman STARK. Do you remember any of them?

Ms. LIPSEN. Consumer Action—there is a whole list of groups. I am sorry.

Chairman STARK. Who are you suing?

Ms. LIPSEN. We are doing—well, the respondents in the case are United American Insurance Co., Globe Life & Accident Insurance Co., Torch Mark Corp., American—

Chairman STARK. Who is Torch Mark?

Ms. LIPSEN. These are all insurance, medigap insurance companies. And I have a whole list.

Chairman STARK. Could you read it?

Ms. LIPSEN. California Association for Concerned Senior Citizens, Consumer Advisory Service, Consumer Referral Service Center.

Chairman STARK. That is not who you are suing. That who is—

Ms. LIPSEN. Well, they are not real consumer groups. That is part of the complaint.

Chairman STARK. OK.

Ms. LIPSEN. Actually—they are actually fronting for insurance groups.

Chairman STARK. I understand.

Ms. LIPSEN. Health Insurance Referral Services, National Health Services, National Senior Advisory Center, Retired Persons Information Center, United Senior Citizens of America, United Seniors of America, Senior Citizens Marketing Group. U.S.A. Lead Systems, Merelli Insurance Agency.

Chairman STARK. OK, so there are only two insurance companies in the group?

Ms. LIPSEN. Well, they are all really insurance companies.

Chairman STARK. They are?

Ms. LIPSEN. Yes.

Chairman STARK. Do you know which insurance companies—

Ms. LIPSEN. It is in the complaint which I will be happy to provide for you.

Chairman STARK. Do you know any off the top of your head? Let me go down a list here that I have just out of curiosity and just see if they are any of them.

Pru, Prudential? You mentioned United American.

Ms. LIPSEN. I am sorry, I cannot get to them very quickly.

Chairman STARK. You do not have it broken out in your—

Ms. LIPSEN. No, we do not have it broken out like that. I would be happy to break it out for you.

Chairman STARK. Yes, I would be curious to know. I wonder if any of the people with you know offhand, to the best of their recollection. If I read down the list which of these—as I say, there is Prudential, United, Bankers Life & Casualty, Standard Life & Accident, Mutual of Omaha, Globe Life & Accident you did mention. And United you mentioned.

Ms. LIPSEN. Right.

Chairman STARK. Natural Home Life, Reserve Life, Pyramid Life, National Foundation Life, Pioneer Life. None of those, I am reading from a list of the largest supplemental insurance carriers, that is all. I do not mean to prejudice them, but you do not have that information with you now.

Ms. LIPSEN. No, but I would be happy to provide it for you.

Chairman STARK. OK.

Mr. DAUB. Mr. Chairman, if I could get the drift. The lawsuit is filed against a specific group?

Ms. LIPSEN. No, it is a petition.

Mr. DAUB. It is a petition.

Ms. LIPSEN. It is a petition before the Department of Insurance.

Mr. DAUB. It is not a lawsuit; it is a petition.

Ms. LIPSEN. It is a petition, yes.

Mr. DAUB. California only.

Ms. LIPSEN. Right. California only.

Mr. DAUB. And are these all named party defendants or party complainer—

Ms. LIPSEN. Respondents.

Mr. DAUB [continuing]. Respondents who do business in California?

Ms. LIPSEN. Yes.

Mr. DAUB. Are they only doing business, is that the nature of your complaint, in California in an improper way or—

Ms. LIPSEN. No, some of them are doing—well, yes, all of them are doing business in California. Some of them are doing business elsewhere. A lot of them actually have mail drops. We could not find registered in California, and they have mail drops in D.C. which is important if you are setting forth information to people that makes them think that you are a Government entity.

Mr. DAUB. I guess I am going where the chairman is going. Are these situs organizations? Are they physically located and headquartered or home officed in California?

Ms. LIPSEN. Some of them are, and—

Chairman STARK. If the gentleman would yield.

Mr. DAUB. Or somewhere else, breaching mail fraud laws and other things besides—

Chairman STARK. Mostly I think with the exception perhaps of two companies, these are groups that are operating as some kind of advocacy group like AARP. I am not suggesting—

Mr. DAUB. Offering in addition to other services, this kind of—

Chairman STARK. Yes, what they really are are insurance agents who do nothing else but sell insurance. I think that is the nature of the complaint.

Ms. LIPSEN. Exactly right.

Mr. DAUB. Thank you, Mr. Chairman.

Thank you very much, ma'am.

Mr. PICKLE. Let me ask you, what is your view about the effectiveness of State insurance commissions with respect to regulation of these health policies? As a whole or the individual States, are they doing a good job or a poor job, or could you comment on that?

Ms. LIPSEN. Some States are doing very well in the regulatory end of things. I believe, 46 States passed legislation responding to the Baucus amendment. However, on enforcement—

Mr. PICKLE. Yes.

Ms. LIPSEN [continuing]. We find that the State departments of insurance have a very spotty record.

Now the Federal Government has not been able to adequately regulate the business of insurance because of the McCarren-Ferguson Act, the antitrust exemption, and so we have to rely on what the States can do.

Mr. PICKLE. Well, I am trying to determine if the State agencies are doing a good job or a poor job, and you are saying, in effect, there is a lot to be desired.

Ms. LIPSEN. A lot to be desired.

Mr. PICKLE. But you do not have a lot of facts because the—

Ms. LIPSEN. We have a lot of facts that deal with the California Department of Insurance, and we have some other—there are other regions of the country but we have not—that we have looked at, but we have not done a comprehensive study.

Mr. PICKLE. I wonder, Mr. Chairman, are we going to have any witnesses from State agencies on this question of catastrophic illness coverage?

Chairman STARK. Well, we are about to hear from some of the insurers. We have not as far as I know scheduled State—

Mr. PICKLE. Well, some time during the hearing process we ought to hear from these State agencies. I think we will find a lot to be desired as far as enforcement on a lot of these policies. We may have a lack of evidence, or information on it, but we ought to look into that.

Chairman STARK. We have another day scheduled with the administration. We could certainly ask the Association of State Insurance Commissioners and I am sure they would be happy to testify. We can add them to the invitation list.

Mr. PICKLE. Well, we have the same problem in the insurance field. The question revolves around to what kind of job are the States doing, if they really are meeting their responsibilities. In many instances the effort is lacking. So I think we ought to hear testimony from the State agencies.

Chairman STARK. Thank you very—

Ms. LIPSEN. Thank you very much.

Chairman STARK. Anybody else?

Mr. CHANDLER. If I could just—

Chairman STARK. Sure.

Mr. CHANDLER [continued]. Underline what Mr. Pickle said. I do not think it is just in insurance that we are seeing this kind of scam, and I think that is exactly what it is. Hearing aids are one of the biggest abuse areas—free hearing tests where they will offer a free hearing aid to poor seniors who qualify. Well, when you get there you find out that is a piece of junk, but they just happen to have a swell program and a full credit deal and they can get you a nice, shiny new one. And so what you are saying is absolutely true—they are probably buying the cussed things when they do not even need them.

Chairman STARK. Thanks very much.

Our next witnesses will consist of a panel made up of Bernard Tresnowski, who is president of Blue Cross and Blue Shield Asso-

ciation; James L. Moorefield, who is president of the Health Insurance Association of America.

Gentlemen, welcome to the committee. Your full statements will be inserted in the record, and please feel free to expand on them or summarize them or explain them in any manner you are comfortable. We will ask you to proceed in the order you appear on the witness list.

Mr. Tresnowski, proceed.

STATEMENT OF BERNARD R. TRESNOWSKI, PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. TRESNOWSKI. Thank you very much, Mr. Chairman. I will be very brief.

Chairman STARK. If I could just ask for those who would like to share with me an interest in this testimony, if as you are moving about, this is a tough room to hear in and if we could just ask the indulgence of our guests and staff to hold the conversation to a minimum.

Go ahead.

Mr. TRESNOWSKI. Mr. Chairman, I am Bernard Tresnowski, president of the Blue Cross and Blue Shield Association. I would like to open my testimony by telling you where the Blue Cross and Blue Shield Association stands on the matter of expanding Medicare to include catastrophic coverage.

While we are proud of the unmatched record we have earned for more than two decades of providing quality Medicare supplemental benefits to nearly 10 million Americans, we believe that the low-income elderly's need for catastrophic medical expense protection is of such urgency that Government action is required.

If adding catastrophic benefits to Medicare will meet these needs, we will enthusiastically support this measure. Further, we believe that the need for long-term care and the threat it poses to both the financial security and dignity of our older Americans remains the most significant problem facing both the elderly and their families.

Thus, our statement covers both the issue of acute care catastrophic benefits under Medicare, the issue before the committee today, and the matter of long-term care, an issue which must be dealt with by both the Government and the private sector.

Regarding acute care expenses, we believe that Blue Cross and Blue Shield plan medigap programs, which cover almost half of all beneficiaries with Medicare supplementary coverage provide beneficiaries with substantial choice, good value and fairly comprehensive coverage. My written statement provides details on the costs, benefits and value of our products. However, the needs of the poor and near-poor for catastrophic coverage for acute care expenses are not being met by medigap programs. Neither are they being met by the Medicare or Medicaid programs.

If you address this problem by expanding Medicare benefits, we would urge you to assure that the financing mechanism not burden those with low incomes. Also, special efforts should be made to prevent beneficiary confusion. We also recommend that you not tax part of the actuarial value of Medicare as a method of protecting the low income.

Instead, we urge you to explore other options to achieve this important objective such as an income-related premium surcharge, or scaling the out-of-pocket expense limits to beneficiary income.

Regarding long-term care, private insurance can play a greater role, although the scope of that role is not yet clear. Government initiatives are needed to educate the elderly about the need for protection, to provide incentives for long-term care insurance and to maintain and improve financing programs for persons who cannot afford private insurance.

Protecting the elderly against the costs of long-term care, and I mean this, both in terms of finances and of human dignity is a major challenge for the Government and the private sector.

We look forward to working with you and helping you in any way we can as you begin to tackle this difficult, complex and very important issue.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF BERNARD R. TRESNOWSKI, PRESIDENT,
BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. Chairman, I am Bernard R. Tresnowski, President of the Blue Cross and Blue Shield Association. I appreciate this opportunity to testify on the issue of expanding Medicare to include catastrophic coverage. The Blue Cross and Blue Shield Association and its Member Plans have been major participants in the administration of Medicare since its beginning. Blue Cross and Blue Shield Plans also underwrite benefits to supplement Medicare coverage for about nine and one-half million beneficiaries, approximately 45 percent of all beneficiaries who purchase such coverage.

There is no question that the Medicare program, as presently designed, does not provide comprehensive protection against costs resulting from acute and chronic illness. For acute care, the Medicare program leaves beneficiaries liable for substantial deductibles and copayments on covered services, for medical fees in excess of the Medicare payment allowance on the one-third of claims that are unassigned, and for a wide range of non-covered services, such as out-patient prescription drugs.

For chronic or long term care, the Medicare program essentially provides no coverage. While this gap in coverage always has created the risk of hardship for Medicare beneficiaries, its adverse effects have been magnified as the incentives of the hospital prospective payment system have resulted in more frequent and earlier transfers of patients to nursing home and home care settings.

These benefit limitations do place beneficiaries at risk for financially catastrophic expenses. The need of the elderly for more comprehensive protection is clear.

The Private Medigap Market

The private sector has taken steps to fill many of these needs. Most Medicare beneficiaries are protected against excessive out-of-pocket costs for acute hospital and physician care by private coverage which supplements Medicare benefits -- Medigap. Overall, 72 percent of the elderly supplement Medicare with private coverage, according to the Congressional Budget Office. About half of this supplemental coverage is provided on a group basis - mainly through retirees' former employers - and about half is purchased individually.

While there is wide variation in the costs, benefits, and availability of Medigap insurance products, we believe the private market has functioned reasonably well to protect the majority of the Medicare population from excessive financial liability for acute care. A 1980 amendment to the Social Security Act, often referred to as the Baucus Amendment, established minimum standards for state regulation and voluntary federal certification of Medigap policies. Forty-six states have adopted regulations meeting or exceeding the Baucus Amendment standards, thereby requiring that certified Medigap programs cover all Medicare hospital coinsurance. Approved programs also must cover at least 90 percent of the cost of at least 365 days of acute hospitalization after Medicare benefits have been exhausted. For Part B expenses, approved programs must cover at least \$5,000 annually in Part B cost-sharing liability, once a \$200 deductible is paid. The four remaining states have adopted their own standards that differ only slightly from those established by the Baucus provision.

Blue Cross and Blue Shield Plan Medicare supplemental programs provide consumers with value substantially in excess of the Baucus Amendment standards, as confirmed by the recent study of the U.S. General Accounting Office (GAO). The GAO study reviewed loss ratios from a sample of Blue Cross and Blue Shield Plan and commercial insurance policies, and concluded that the Blue Cross and Blue Shield Plan programs had a substantially higher aggregate loss ratio than did the commercial products.

Moreover, when we review all Blue Cross and Blue Shield Plans' Medigap products, we find loss ratios even higher than those calculated by GAO in its sample of Plans. The loss ratio measures the portion of the insurance premium that goes to pay benefits -- the higher the loss ratio, the greater the percentage of premium paid in benefits to or on behalf of subscribers. The Blue Cross and Blue Shield organization's aggregate 1979-1984 loss ratio on Medicare supplemental products was 90.8 percent, and many Plans incurred

annual loss ratios exceeding 100 percent. Thus, we believe that Medigap products offered by Blue Cross and Blue Shield Plans provide good value to elderly consumers.

Blue Cross and Blue Shield Plan Medigap products offer substantial choices for coverage of acute care expenses that are neither covered by Medicare nor required under the Baucus Medigap standards. In 1985, for non-group products, we estimate that 88 percent of Plan products covered Part B expenses beyond the \$5,000 minimum required under the Baucus Amendment, 84 percent of products covered each hospital deductible, 86 percent covered Skilled Nursing Facility copayments and 63 percent covered the \$75 Part B deductible. In addition, 43 percent of Plan products included coverage for prescription drugs, 36 percent covered Skilled Nursing Facility days after expiration of Medicare benefits, and 29 percent included vision care coverage. We estimate that almost half of all Plans provide some protection against physicians' fees in excess of Medicare's allowed charge. This is usually accomplished by calculating the Medigap payment for Part B coinsurance using private UCR screens as a base. In some cases, Blue Cross and Blue Shield Plan programs also provide benefits such as wellness education, psychiatric benefits beyond Medicare, and convalescent homemaker services.

While comprehensive coverage is preferred by most Medigap buyers, many Blue Cross and Blue Shield Plans also offer less extensive and less costly coverage. This variety of coverage options is reflected in Plans' Medigap premiums, which ranged from \$18.13 to \$130.00 per month for non-group products in 1985. In that year, we estimate that 10 percent of all our non-group Medigap subscribers paid \$20 or less per month, 40 percent paid \$30 or less, and 75 percent paid under \$43.

Defining the Problem

While we believe that the Medigap programs offered by Blue Cross and Blue Shield Plans represent a "good buy" for most beneficiaries, there are those who cannot afford any private Medigap coverage. According to a study funded by the Health Care Financing Administration, about half of the beneficiaries without supplemental protection said they simply could not afford it.

This finding is confirmed by a Congressional Budget Office (CBO) analysis showing that low income beneficiaries are the ones most likely to lack supplemental coverage. According to CBO, nearly 30 percent of the elderly with incomes under \$9,000 had no coverage in addition to Medicare, versus only 10 percent of those with incomes above \$25,000. CBO also found that Medicaid fails to cover 72 percent of the elderly with incomes under \$5,000. Thus, a major coverage gap left by Medicare, Medicaid, and private Medigap programs is the failure to provide adequate coverage of acute care expenses for the low income elderly.

The other major gap that is not presently being filled is the lack of catastrophic coverage for long term care.

Thus, in our view, the major problem of catastrophic health care for the elderly is twofold:

- 1) For acute care catastrophic expenses, the most significant problem is the affordability not the availability of adequate private health insurance, and,
- 2) For long term care, the problem is both one of affordability and availability. Medicaid requires individuals to become impoverished before becoming eligible for long term care coverage. Also, for a number of reasons, the private insurance market has moved cautiously in this area, representing only two percent of all spending for long term care.

In addressing proposed solutions to these problems, however, it is important to examine the role and responsibilities of the government and the private sector in assuring access to adequate health care coverage.

Public and Private Sector Responsibilities

Our society has traditionally looked to government to help those who cannot provide for their own financial security or obtain financial access to health care coverage. Government also has an important role in assuring that consumers receive reasonable value in the market. This responsibility takes the form of assuring that beneficiaries are not victimized by improper sales techniques or by insurance that provides an unreasonably low value. The enactment of the Baucus amendment in 1980 after documentation of abuses was a significant step in fulfilling that responsibility. The GAO report confirms that the Baucus Amendment generally has been successful in achieving its objectives. Government also can play an important role in supplementing private sector efforts designed to assure that beneficiaries are well informed to shop effectively for private coverage.

In the context of catastrophic coverage for the elderly, we believe that the government has an obligation to help assure that low income persons who cannot now afford private coverage are adequately protected. The private sector, in our view, has a responsibility to develop innovative products that respond to consumer needs, to provide a fair value to the consumer, to educate consumers, and to help contain health care costs. We believe that the Blue Cross and Blue Shield organization's overall record in the Medigap market and our involvement in making capitated systems available to the elderly reflect our commitment to these responsibilities.

Recommended Solution

Our recommended solution to the acute care catastrophic problem is to have the federal and state governments target their efforts to help the low income elderly, using general revenue financing to improve Medicaid coverage or to provide special financial assistance for the purchase of private coverage. Also, if further examination of the standards and consumer protections in current law shows them to be inadequate, they should be strengthened. Our Medicare supplemental products generally provide benefits and value far beyond the minimum requirements of the law, but we do not represent the whole market.

We recognize, however, that with the President's endorsement of Secretary Bowen's proposal and the widespread bipartisan Congressional support of the Secretary's general approach, the consensus view is not to spend additional federal money to solve this problem. The consensus approach is to incorporate this acute care catastrophic insurance protection in the Medicare program. We support this approach but urge that the design of the legislation consider carefully two fundamental aspects of the benefit -- financing for low income beneficiaries and beneficiary education. We would also urge you consider carefully the future costs of these benefits and the effect of Medicare catastrophic coverage on alternative delivery systems such as HMOs and CMPs.

Financing for Low Income Beneficiaries

Since we view the problem of inadequate catastrophic coverage for acute care expenses as one of affordability, we believe strongly that the financing mechanism should not place undue burdens on those with low incomes. Assuming that no federal funds would be used to subsidize the new benefits, this can be accomplished in one of two ways: (1) scaling down the benefits so that the premium to be paid by all beneficiaries is truly affordable to the low income, or (2) incorporating an ability-to-pay measure in the financing mechanism or in the design of the catastrophic benefits.

As a practical matter, the first approach is not feasible. We believe it would be extremely difficult to design a reasonable catastrophic benefit yet keep its average premium costs affordable to low income persons. For example, even if HHS's estimate of a \$4.92 monthly premium for Secretary Bowen's program in 1987 was accurate, this amount would not be affordable to many lower-income beneficiaries. To illustrate this, we would note that beneficiaries entitled to the average Social Security monthly cash benefit received a 1987 cost of living adjustment of \$6.00 per month. The new \$4.92 monthly premium plus the 1987 increase of \$2.20 in the regular Part B premium thus would wipe out the entire cost of living adjustment for the average beneficiary. This would reduce the real value of the cash benefit.

Beneficiaries could face additional financial difficulties under the Administration's proposed increase in the basic Part B premium. Even if the basic Part B premium calculation were not changed, beneficiaries will face an estimated premium increase of \$4.10 in 1988. By 1992, the Part B premium will increase to \$26.00 under CBO's current law estimates.

Since it is not feasible to keep the average premium costs of the new benefits down to a level affordable to all beneficiaries, then the second approach -- incorporating an ability-to-pay measure into the financing or benefit design of the program -- should be considered.

With respect to specific approaches to incorporate ability-to-pay measures into Medicare, we recommend against taxing a portion of the actuarial value of Medicare benefit coverage. This approach would establish an open-ended liability for the taxpayer elderly to finance rapidly increasing Medicare costs and the cost of any new benefits. Moreover, since Medicare Part A is neither a cash benefit nor an "insurance" arrangement in the traditional sense, the rationale for such an approach appears questionable. Finally, taxing the actuarial value of Medicare could, by precedent, encourage increased taxes on employer paid health benefits for the general population. A reduction in tax incentives for employer paid coverage would only exacerbate the problem of covering the uninsured and underinsured.

As alternatives to taxing the actuarial value of Medicare, we urge you to consider:

- (1) An income-related premium set to finance the cost of catastrophic benefits only, added to the tax liability of beneficiaries who must file tax returns. For example, in addition to the regular Part B premium, beneficiaries in the 15 percent tax bracket might be required to pay as part of their tax filing an additional \$100 premium to help finance Medicare catastrophic benefits; beneficiaries in the 28 percent bracket could be required to pay a higher amount. The precise thresholds and dollar figures to be used under this approach would need to be determined based on detailed cost estimates and policy considerations.
- (2) Tying the catastrophic benefits to ability-to-pay, financed by an affordable level premium paid by all beneficiaries. For example, this approach might involve a \$2,000 cap on out-of-pocket liability for most beneficiaries but a higher cap for those who exceed the income threshold that triggers taxation of Social Security benefits. Again, the precise figures would be a matter for technical analysis and policy judgment.

Beneficiary Education

An equally important issue is the need to minimize beneficiary confusion over the new program that is being considered. We know from our experience as Medicare contractors and as the major underwriter of Medigap coverage that beneficiaries now believe Medicare benefits are much richer than they actually are. We are concerned that a new federal catastrophic program could give many beneficiaries a false sense of security that could lead them to drop private coverage for the remaining acute care coverage gaps; discourage public interest in long term insurance; and reduce public understanding of the catastrophic spend-down requirements needed to obtain eligibility for Medicaid benefits.

The enactment of a new federal program also will result in activity in the marketplace and in the regulatory environment for Medicare supplemental insurance that may be confusing for beneficiaries. Many, if not most, of the minimum benefits for Medicare supplemental products adopted by states and encouraged by the 1980 Baucus amendment will be made superfluous by the inclusion of catastrophic benefits in Medicare. Thus, legislative and regulatory activity within the states will evolve over time to adapt to the new Medicare benefits.

We would be pleased to work with the Subcommittee, HHS, and state insurance commissioners on ways of minimizing beneficiary confusion over any new legislation providing catastrophic coverage.

Future Costs of Catastrophic Benefits

As you consider specific proposals to include catastrophic coverage in Medicare, we would urge you to assess carefully the estimates of future year costs. The historical record of Medicare illustrates how difficult it is for anyone to predict accurately the cost of new benefits. A particularly difficult problem is predicting the behavioral response to the changes. With regard to catastrophic benefits, it will be important to assess the potential for inducing demand for services, particularly among beneficiaries not now covered by private Medigap programs. The importance in this area of accurate cost estimates is underscored by the difficult decisions that the Congress must make regarding the sources of financing for the new benefits.

Effect on Alternative Delivery Systems

We also would urge you to consider the effects of Medicare catastrophic benefits on the capitated delivery system. To the extent that beneficiaries believe that the new benefits provide complete protection against the cost of acute illness, they may be disinterested in the comprehensive benefits offered by most HMOs and CMPs. This reinforces the need for beneficiary education. In addition, if it is determined that the introduction of the new benefits might seriously impede the growth of Medicare HMO enrollment, the Congress may wish to explore explicit incentives for joining HMOs.

H.R. 1280 and H.R. 1281

The catastrophic coverage bills recently introduced by Representatives Stark, Gradison, and other Members of the Committee basically would expand Medicare to provide greater protection against the costs of acute care hospitalization, skilled nursing care meeting Medicare's coverage criteria, and physicians' services. To help finance these new benefits, a part of the actuarial value of Medicare Part A and Part B would be added to beneficiaries' adjusted gross income in determining their total tax liability.

Our comments on these bills are as follows. First, the elimination of the "spell-of-illness" concept in Medicare is long overdue. It has complicated program administration and is a constant source of confusion among the elderly. Its elimination will be welcomed by all.

Second, we support the use in H.R. 1281 of an out-of-pocket limit on Part B expenses only. Given the design of Part A benefits, it is not necessary to link them to an out-of-pocket limit to assure catastrophic protection. Eliminating the spell-of-illness and providing 365 days of covered care, eliminating hospital coinsurance, and limiting the number of deductibles that can be incurred in any year effectively provides catastrophic protection for inpatient hospital services. A combined Part A and Part B out-of-pocket cap would also be more difficult and costly to administer.

Third, given the volatility that we have seen in the Part A hospital deductible which, prior to 1987, was based on the average cost of a hospital day, we would suggest that you do not use the same approach for the new coinsurance on the first seven days of skilled nursing facility care. Alternatives include setting the SNF coinsurance at a fraction of the hospital deductible or at a fixed dollar amount, increased annually by an update factor.

Fourth, we recommend that the bills or the committee reports explicitly direct that the capitation payments paid to HMOs and CMPs participating in Medicare be adjusted upward to reflect the estimated costs of the new Medicare benefits.

Long Term Care

As we weigh the important public policy issue of how best to relieve the elderly of the fear of financially devastating health care expenses, we cannot overemphasize that the largest coverage gap is the lack of adequate long term care protection. As I mentioned earlier, the magnitude of this problem is increasing as the locus of health care shifts away from the acute care hospital setting. Thus, the major issue is how to improve public and private financing mechanisms for long term care.

Although the private insurance industry is beginning to respond to this need, we are not certain what portion of the long term care coverage gap can be filled by private initiatives. For example, meeting the long term care needs of those individuals who are already very old, have severe chronic illnesses, or have inadequate resources to devote to additional insurance will require a strong commitment of federal and state resources. Further, if we are to move away from the notion that the resources of the middle class should be decimated before Medicaid will help finance long term care, liberalizing Medicaid eligibility requirements must be considered. This, too, will require additional resources at the federal and state levels.

With respect to the long term care insurance, we recently completed an extensive examination of the potential market and the actuarial issues involved in developing sound products. We found substantial interest among consumers in long term care insurance. Based on our analysis, however, there are a number of uncertainties related to the funding of future year long term care expenses. As a result, Blue Cross and Blue Shield Plans will proceed carefully to develop and offer long term care insurance products.

One Blue Cross Plan entered the long term care insurance market in 1986. In addition, several other Plans are developing programs that they may introduce in 1987 on a pilot or broader basis. The experience to be gained by these efforts will be invaluable in determining more precisely what types of products best meet consumer needs and what data and techniques are most effective in establishing financially sound rate structures and in managing long term care benefit costs.

To facilitate private sector initiatives, we believe that government can play an important role in educating the public about the long term care gap in Medicare and the eligibility requirements for Medicaid coverage. Our own study showed that 54 percent of the elderly surveyed believed incorrectly that they already were covered for long term care. It also is appropriate to consider government incentives for the offering and purchase of long term care insurance. For example, one option that deserves careful consideration is permitting the tax-favored accumulation of long term care insurance reserves. Such a change would lower premium costs and provide an incentive for individuals to purchase coverage before they become elderly or need long term care services. It would also permit a greater portion of the interest earned on the reserves to be used to pay for long term care services. We would be pleased to work with the committee to explore this option further.

The complexity and magnitude of the long term care problem defies any easy solution. Moreover, we believe that it is both unrealistic and unproductive to frame this issue in terms of private versus public solutions. Addressing the long term care needs of the elderly will require and should as a matter of principle involve a combination of public and private sector initiatives. Solving this problem will require a major societal commitment of resources and creative energies to develop innovative solutions that preserve the dignity of our nation's elderly.

Conclusion

I appreciate the opportunity to present our views on this important matter. But it is time to act and thus I wish to tell you where the Blue Cross and Blue Shield Association stands on the legislative initiatives you are considering.

While we are proud of our unmatched record gained in more than two decades of providing quality Medicare supplemental benefits to nearly 10 million of our citizens, we believe that the unmet needs of the low income elderly for protection against catastrophic medical expenses are of such urgency that government action is required.

If incorporating catastrophic benefits into Medicare meets these needs, we enthusiastically support such legislation.

We also believe that the threat to both the financial security and dignity of our older Americans posed by the need for long term care remains the most significant problem facing both the elderly and their families. Both public and private sector initiatives are needed to begin to solve this complex problem. We look forward to working with you on this important issue.

Chairman STARK. Thank you very much.
Mr. Moorefield.

**STATEMENT OF JAMES L. MOOREFIELD, PRESIDENT, HEALTH
INSURANCE ASSOCIATION OF AMERICA**

Mr. MOOREFIELD. Thank you, Mr. Chairman, gentlemen of the committee.

I am Jim Moorefield. I am currently president of the Health Insurance Association of America. Seven weeks from now, however, I will be relinquishing my duties as president to my successor, and in less than 4 months I will become one of those eligible for Medicare. So I have a very special interest in the hearings and the results of your actions and the actions of the Congress.

Mr. Chairman, I had the pleasure of serving with you and Barnie Tresnowski as a member of Secretary Bowen's private/public sector advisory committee on catastrophic illness, and as you were, sir, I was also critical of the Secretary's charge to the committee limiting us to recommending options for his consideration rather than being more specific in addressing some of the target groups which I think you and I and most of us believe should be addressed.

Nevertheless, after hearing from more than 100 witnesses that appeared in the cities across the states where public hearings were held, the advisory committee was unanimous, I want to remind you, sir, in its findings.

First, that the real catastrophic needs to be addressed and addressed immediately, was, first, that of providing long-term care coverage, which includes intermediate and nursing home care, custodial care, at home and in the nursing home; second, providing the basic catastrophic health insurance for those 35 to 37 million who are without health insurance, those whose insurance is inadequate to cover catastrophic illness, the working poor, or near-poor, the uninsurables, and those who are unemployed.

The third thing that they were unanimous in was the need to provide adequate coverage to those 3 to 5 million people, sir, who are over age 65 that do not qualify for Medicaid and cannot afford private insurance.

The committee was also unanimous in finding that the vast majority of the Americans under age 65, some 172 million of them, are adequately protected against catastrophic acute health care expenses, primarily through group policies provided by the employers, but also by individually purchased policies. And that as many as 80 percent of those over age 65 are protected against catastrophic care through the Medicare program in combinations with medigap coverage or other medical supplement policies and/or Medicaid.

Medicare, sir, is doing an excellent job in our opinion, and when it is coupled with these other private policies or the Medicaid program, it is doing an extremely good job for all.

The HIAA compliments Secretary Bowen, President Reagan, you, sir, and members of this committee and others in Congress who are bringing the issues of catastrophic illness to the forefront, calling it

to the public's attention, providing the forum where we can discuss the issues and reach viable solutions.

I appreciate that the administration and you, sir, have promised to look at the long-term care needs and the needs of the poor at some time, hopefully in the near future, and I also respect the problems that the administration and the Congress are facing on the deficit and where the money is coming from to finance those problems.

But, sir, in all due respect, I would be less than honest if I did not say, I have been very disappointed in that the administration and you have seemed to place the first emphasis, the first need on revising or restructuring the Medicare program, a program that is working so well, working so well. It can be improved, but it is working.

I respectfully submit, then, that the focus of this committee should not be on the restructuring, which I think is misdirected, but should be on the long-term care needs of all of the public and on the poor and near-poor of all ages.

You should not spend your time or the public funds to replace a program that is working, that is providing adequate care for most Americans.

Now we are proud, Mr. Chairman, and gentlemen, of our industry's record, as Bernie is of the Blue Cross record, in providing coverages. Most qualified medigap policies being written today provide coverage that exceeds the Baucus standards, and many provide benefits even more than the Secretary or you are proposing.

We suggest, sir, that the private industry can respond to the problems of those who can afford insurance, and we can offer solutions to you for those near-poor or poor who will need some subsidy. But if you feel it is necessary to push the industry, into doing more, then it is very simple, although we know, as Mr. Daub and others from the insurance states know, that several companies have already volunteered to write a Bowen plan, and add it to their policies without cost.

But if you feel there is really more to be done to urge other companies to do it, we suggest that you reexamine Baucus, expand those minimum standards to include a catastrophic benefit, however you may define it. That would assure that the future policies would be offering it.

Furthermore, someone said that the industry has not stood up to its responsibility in issuing catastrophic policies. I suggest that we could respond better, sir, if we could preempt the state laws that mandate all sorts of types of benefits. That would allow the companies to issue a basic catastrophic, stripped down, simplified policy.

We could do it at much lower rates and we could do it with rates comparable with some of the premiums being suggested as necessary in the future for the Bowen plan, and certainly with the additional taxes that would be imposed upon the 28 percent bracket under the Stark-Gradison plan, sir.

Now there are more viable solutions to those other critical problems. They are outlined in my statement which you have in hand. You have heard and will hear from those that support some of our solutions and you will be hearing others.

Mr. Chairman and gentlemen, I just want you to know that the HIAA stands ready to be of whatever assistance we can to you.

Thank you.

[HIAA submitted a document, "A Report on Medigap Insurance Policy Ownership and Expreience," which has been retained in the committee files. The prepared statement follows:]

Statement
of the
HEALTH INSURANCE ASSOCIATION OF AMERICA

James L. Moorefield
President

I am James L. Moorefield, President of the Health Insurance Association of America. The HIAA is a trade association with a membership of about 335 insurance companies. Our members write about 60 percent of the health insurance available in this country.

The nature of our business has given the HIAA considerable experience in the field of health benefits over the last thirty years. We urge you to use this practical knowledge as you study the health care needs of people in this country.

To judge from news reports, the question of the hour is: Do Americans run the risk of financial ruin when faced with a catastrophic illness? In his report to the President last November, HHS Secretary Bowen said that the present health care system provides substantial benefits to most people. He noted that virtually all the elderly and nine out of ten people in the general population have health insurance. But he warned of gaps in catastrophic coverage that need to be filled, especially for older Americans and the working poor.

In the case of the elderly, some of these gaps have already been closed by a partnership between government and private insurers that protects older people from catastrophic hospital and medical bills. Medicare pays a large portion of the elderly's expenses for acute illness and private insurance policies known as "medigap" pick up the deductibles and coinsurance -- those gaps in coverage that Medicare assigns to the elderly to pay themselves. Today, seven out of ten older people have some form of private insurance or medigap to supplement their Medicare benefits thereby avoiding catastrophic hospital and medical bills.

A medigap policy allows older Americans to spend up to 150 days -- that's nearly five months -- in a hospital without paying any Medicare coinsurance. And, if an elderly patient exhausts his 150 day Medicare hospital benefits, but needs to remain in the hospital, his private medigap policy will cover another 365 days, paying at least 90 percent of all Medicare allowable hospital expenses.

In addition to covering hospital expenses, medigap policies help older people with some of their other medical expenses, particularly doctor's bills. Medicare pays 80 percent of these medical bills after determining the "reasonable and customary" charge for the services performed. Private medigap policies pick up the remaining 20 percent of expenses allowed by Medicare up to at least \$5,000 a year.

Medigap policies are regulated by the states and must meet the standards I just described. These minimum standards were set by the Baucus Amendment to the 1980 Social Security Disability Act, an amendment designed to protect the elderly from overpriced or substandard medigap insurance policies. The standards set up by the Baucus amendment have been adopted in 46 of the 50 states, Puerto Rico and the District of Columbia.

In addition to enforcing minimum coverage standards for medigap policies, state laws also require insurers to pay benefits for pre-existing health conditions after the medigap policy has been in force for six months. Benefit payments must increase to keep up with rising health care costs along with changes in Medicare co-payments and deductibles. Older people are allowed to return the policy within 10 days for a full refund. Companies that sell Medigap insurance are also bound by fair trade practices such as simplified policy language and truth-in-advertising designed to protect the consumer.

I should also point out that current state law requires insurers to provide medigap consumers with simplified explanatory materials which describe what benefits Medicare and medigap policies do and do not cover. This Guide to Health Insurance for People with Medicare was developed by the National Association of Insurance Commissioners in coordination with the HIAA and the Health Care Financing Administration.

The conditions I have just mentioned are purely minimum standards that most medigap policies surpass. Many provide "first dollar" coverage by picking up the Medicare Part A hospital deductible (currently \$520), as well as the Part B annual medical deductible of \$75. A recent HIAA survey of 11 top commercial medigap carriers (comprising about 51% of the entire medigap market) shows that 84% of their policies covered unlimited hospital days, paying 100 percent of all Medicare allowable hospital expenses. The same survey showed that 92% of those companies' policies had unlimited coverage for Medicare allowable Part B expenses. Some medigap policies also cover expenses that Medicare will not pay for at all, such as dental and vision care, routine check-ups, hearing aids and out-patient drugs.

Last year, the GAO was asked to investigate the effectiveness of the Baucus Amendment in assuring the elderly that medigap policies meet their needs. The congressional watchdog agency reported its findings to the House Ways and Means Subcommittee on Health last October. In its review of 142 policies sold by 92 commercial insurers and 13 Blue Cross/Blue Shield plans, the GAO made no recommendations for further controls since, it said, the elderly were receiving adequate protection.

The GAO report also found that medigap policies sold by commercial companies with more than \$50 billion in premiums generally met the Baucus loss ratio requirements. That means that at least 60 cents of every premium dollar was returned as benefits or added to reserves. The loss ratios for the most commonly purchased policies, however, generally exceeded the recommendations found in the Baucus Amendment. For example, coverage sold by the Prudential Insurance Company for AARP members must by contract pay 80 cents of every dollar in benefits. Currently, about 10% of all Medicare beneficiaries have such coverage through the AARP. It is also important to point out that HIAA surveys show that nearly 40 percent of all medigap is purchased on a group basis. The Baucus Amendment requires all medigap sold on a group basis to pay at least 75 cents of every premium dollar in benefits.

The GAO report concludes that the protection these policies give the elderly could be considered a form of catastrophic health insurance. But the report also noted that few Medigap beneficiaries need this benefit since HCFA data shows that only about 2,000 Medicare beneficiaries, or .007 percent of people 65 and older, spent more than 150 days in the hospital in 1984.

It would seem then that older people who have bought medigap policies do not need to worry about catastrophic hospital expenses. They are, however, exposed to more serious financial consequences when faced with doctor bills since Medicare will only pay 80 percent of what it considers "reasonable and customary" medical charges. Even though medigap insurance picks up the remaining 20 percent of the Medicare allowance, older people are still responsible for paying the difference between what their insurance reimburses and what their physician charges.

Older people would be helped with this problem if the Health Care Financing Administration helped them identify those physicians and other providers who accept Medicare's fees as full payment for their services. HCFA could publish directories with the names and addresses of participating physicians and even provide toll-free hotlines. It could also develop incentives for electronic billing of physician claims as well as for streamlining the coordination of billing for Medicare and Medigap benefits.

We would also encourage Medicare to be more aggressive in its pursuit of cost containment. This means more stringent utilization review, pre-admission certification and mandatory second surgical opinion programs. These are all techniques used routinely in privately managed health care plans.

In spite of these problems, Medicare and private health insurance are protecting most of the nation's elderly from catastrophic acute care costs. In January 1987, the HIAA commissioned Market Facts, one of the largest marketing firms in the country, to assess consumer experience with medigap policies. Over 1,500 people 65 and older who have medigap policies were surveyed from a demographically balanced national sample. The survey found that 8 in 10 say they were not pressured into purchasing a medigap policy and an equal number say that their policy was fairly priced. Among those who have already filed a claim with their medigap insurer, 8 in 10 say that the claim

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was promptly paid and that the insurer paid as much of their medical costs as they expected. The survey also revealed that 9 in 10 of the people who filed a claim were satisfied with their policies. I have brought copies of a detailed report on this survey with me today which I will distribute to anyone interested in it.

Our research also indicates that Medicare and private health insurance are protecting about 70 percent of the nation's elderly from catastrophic acute care costs. Medicare and Medicaid cover another 10 percent, leaving 20 percent of those 65 and older vulnerable to the gaps in Medicare's hospital and medical benefits. About half of these people can afford private supplemental insurance, but have chosen not to purchase it. The remaining 10 percent of the elderly have no medigap insurance, but are not eligible for Medicaid. These are the elderly who need help most.

There are several ways to fill their gaps in coverage. One would be to encourage more employers to provide health insurance benefits to their retired workers. The U.S. Department of Labor reports that currently only 57 percent of employees in large and medium-sized companies will receive employer-provided health benefits that supplement Medicare when they retire. Although this percentage is expected to grow, coinciding with the growing number of the elderly, the present federal tax policy is a major reason why many more employers are choosing not to do more for their retirees.

Specifically, the Deficit Reduction Act of 1984 has limited the tax advantage to pre-funding retiree health benefits. The HIAA urges Congress to consider the wisdom of a federal tax policy that discourages people from making financial arrangements today which would help pay for their health care tomorrow.

LONG TERM CARE: THE REAL CATASTROPHE

Pre-funding for retiree health care would also help working people prepare for the biggest catastrophic health care cost of old age -- long-term care, the catastrophic expense that 90 percent of the elderly are unprotected from today.

A recent study, financed by the National Center for Health Service Research, determined that older people who had more than \$2,000 worth of out-of-pocket expenses in a given year, spent 81 percent of this additional expense on nursing home care. At the same time, their annual out-of-pocket expenses for hospital and physicians fees were respectively 10 and 6 percent.

Most people do not realize the enormity of the risk they run when facing long-term care. In 1985, the insurance industry conducted a survey of 1,000 Americans between the ages of 50 and 64. Through it we learned that although more than half of them worry about a chronic illness or disability in their old age, less than one-fourth of them know that Medicare will be of little use to them should they ever need long-term care. Even more telling is the finding of a recent survey of the elderly by the AARP: about 80% believe Medicare covers long-term care.

Misconceptions about government assistance in paying for long-term care are echoed in popular beliefs about the role that private insurance plays in providing this kind of protection. In spite of industry educational campaigns, many older people still think that they already have long-term care coverage because they own a medigap policy. But medigap insurance is not long-term care insurance. Medicare's coverage of long-term care is limited and since medigap policies are designed to supplement Medicare, medigap long-term care benefits are also limited.

In an effort to eliminate these misconceptions, I personally offered the HIAA's assistance to HHS Secretary Bowen in embarking on two educational campaigns regarding the benefits and limitations of the Medicare program and the need for financial protection against expenses associated with long-term care. Our discussions have focused on targeting middle-aged sons and daughters of the elderly, as well as the elderly themselves. Although this effort is still in an exploratory stage, we feel the prospects for the campaign are promising.

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The HIAA also has recently expanded existing educational programs regarding the need for long term care and defining what is and is not covered by Medicare and medigap. Following are some of our activities:

- o Educational booklets for consumers, policymakers, and legislators.
- o Op-ed and other advertising focusing on long-term care, Medicare and medigap (a medigap "Know Your Rights" ad has run in 50 Plus magazine and will soon run in newspapers in selected areas of the country).
- o Consumer and agent-oriented slide shows.
- o A consumer 800 number for information on the availability of long term care insurance in every state.
- o Media seminars on long-term care.
- o Long-term care kits for HIAA member companies designed to encourage development of new products.

Americans may not yet have accepted the idea that they need long-term care protection, but private long-term care insurance is available. In 1986 we surveyed our member companies and found that as of June 1986, 12 of them were offering individual long-term care policies of the indemnity-type. These are policies which offer a fixed amount of money per day. Since completing our survey we learned that four more member companies have entered the market. Today, an average of six HIAA companies are selling policies in each of the 50 states.

What is covered by the typical private long-term care policy? In our survey, we defined this type of policy as one which covers nursing home stays and/or home health care for not less than 12 consecutive months. The maximum benefit period for a typical policy, however, is 3 years, although a substantial number offer 5 years of coverage. This coverage appears to be adequate since one half of all nursing home residents stay only 90 days and 93 percent of all residents are discharged within 5 years.

Services covered in these policies include skilled, intermediate, custodial and home health care. Of the 12 policies analyzed in our survey, all offer skilled nursing care, 10 also provide intermediate nursing and custodial care, 8 include home health care, and 2 pay a cash benefit for purchasing necessary care at home.

We do not know how many long-term care policies have been sold because many companies have just entered the market. The companies that do have tallies, however, tell us that there were about 130,000 policyholders as of January 1986. Their average policyholder is 75 years old.

Another 15 HIAA companies are developing new long-term care products. Many of these are "group" policies which means they can be sold at a lower premium with little or no individual underwriting.

We believe that private long-term care insurance can play an important role in protecting many elderly from catastrophic long-term care costs. However, consumer education regarding the shortcomings of existing coverage is critical to the success of any long-term care financing scheme.

CATASTROPHIC PROTECTION FOR THE UNDER 65 POPULATION

But what about the people who are under 65 years of age? For the working population, studies of group health insurance plans offered by employers show:

- o 172 million individuals have major medical coverage providing hospital and medical benefits.
- o Nearly 80% of working people today having maximum benefits of \$1,000,000 or more (compared to 46 percent in 1980).

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o 91% of all insured working people have limited out-of-pocket expenses of \$2,000 or less (compared to 75 percent in 1980).

o Over 99% of all insured employees are covered for inpatient expenses associated with mental and nervous disorders.

o Over half of all insured employees have coverage for home health care and almost two thirds for second surgical opinions.

For the working poor, who earn less than \$10,000 a year, but have no health insurance benefits, we suggest that Congress enact incentives to encourage small companies to cover their employees. Dr. Bowen proposed offering the self-employed full deductions on their own health insurance plans as long as they cover their employees as well.

We would also urge that state mandatory benefit laws be removed so that insurers can offer less expensive catastrophic-only health plans to small employers. States could also be given greater flexibility with Medicaid programs in order to cover the medically needy independent of other welfare programs and to cover low-income working parents, as well. It might also be possible to offer a subsidized Medicaid "buy-in" for uninsured low-income people who are not eligible for Medicaid.

We cannot fail to mention those who have no health insurance because they have chronic health problems such as diabetes, heart disease or AIDS that have made them ineligible for private individual insurance. Many of these individuals are working or can otherwise afford to buy coverage. The HIAA supports proposals to make health insurance available for those who find themselves in this situation. Last year, we supported legislation introduced during the 99th Congress by you, Chairman Stark, and Representatives Kennelly, Gradison, Rangel and Matsui, which would encourage states to establish risk pools for people considered uninsurable. We expect similar legislation to be introduced this year and we will continue to support these efforts.

Eleven states currently have some form of risk pool that offers comprehensive major medical insurance to high risk people. The pool operates like any other private insurance plan. If the pool experiences losses, those losses are shared by all insurers in the state. The pool would be established in the states and regulated like other state insurance. The federal legislation simply establishes minimum standards based on the experiences of successful state pools and ensures a fair distribution of pool losses.

Most important, the state high risk pool would ensure the availability of health insurance for all Americans, regardless of health condition, with minimum federal regulation and at no cost to the federal treasury.

Finding ways to protect Americans from catastrophic health bills is complex because the elderly, workers, the poor and the uninsurables have different needs. Solving their problems will take time and ingenuity on the part of the legislators and insurers. But I think it is important to stress that our state and federal resources are limited. And what funds we have should be used to help the most vulnerable among us. Public money should not be spent to replace coverage adequately provided to the majority by the private sector.

Thank you, Chairman Stark and members of the Subcommittee for this opportunity to testify. The Health Insurance Association of America is willing to offer its assistance to this committee as you deliberate this pressing national issue.

Chairman STARK. Thank you, gentlemen. I thank both of you. I have special thanks, of course, to Mr. Tresnowski and the Blue Cross/Blue Shield group for endorsing the general direction that this committee is trying to go in. We appreciate that because I suspect that some of that comes at a revenue loss to your members. Putting principle ahead of profit is something I thought only Congressmen did and that is appreciated.

And I would ask you this. I share with you a concern about how you income relate. And as far as I am concerned, I do not see any difference between income relating a premium or a deductible and taxing. The curve does not fit maybe as well, depending on whether you use the tax system or whether you direct income relate, but we were unable to find a simple income relating mechanism.

You could make the assumption that Social Security benefit checks somehow relate to past income and therefore might be a good indication of retirement income. But there is an awful lot of inconsistencies in that. The only system we could find, quite frankly, that was easy, was the Tax Code. And we would be anxious, because I am not sure that as this committee moves ahead, that the proposal, either the premium and/or the complete taxation of the actuarial benefit, will not end up not being compromised.

So, if you have any ideas as to how we could relate this to income, we would appreciate them.

Mr. TRESNOWSKI. In my statement, first of all, is a fundamental point. As I said, we are supporting this legislation provided it takes care of the low income. If it does not do that, then it does not serve any purpose at all. We are not anxious to give up our record, which is an outstanding record, if the legislation simply supplants us for another Government program.

Our concern about the actuarial equivalent approach is that it provides an open-ended opportunity for adding additional benefits in the future without explicitly acknowledging that in the proposal.

We offer two alternatives to that. One is a graduated premium, but on the basis of the filing of an income tax. A beneficiary in the 15 percent tax bracket for example, might pay \$100. A beneficiary in the 28 percent tax bracket would pay something above that. That would finance the program. That would automatically take care of the low income because obviously they would not pay any taxes.

Chairman STARK. That is really what we are saying. The only difference is under our program it would be \$270 for the 15 percent people. In other words, 15 percent of the \$1,800 actuarial benefit. And so it seems to me we are only talking about dollars.

Mr. TRESNOWSKI. Well, no, there are another couple important points.

One, the surcharge is a very explicit amount of money. It would have to be considered every year in order to make sure it truly financed the program. That gives it greater visibility.

The other concern I have about an actuarial equivalent is you are talking about the principle of taxing health benefits. And once you have crossed the bridge on taxing health benefits, you open the door for something which we strongly oppose.

Chairman STARK. There is a finite difference here. It is not taxing the benefit if you mean the payment in terms of a hospital day or a physician's charge.

Mr. TRESNOWSKI. No, it is an actuarial equivalent though.

Chairman STARK. No. It is the actuarial equivalent of the value of the insurance.

Mr. TRESNOWSKI. That is right, and you are taxing that.

Chairman STARK. Yes.

Mr. TRESNOWSKI. And that is what we are concerned about. That that sets a precedent for taxing health insurance premiums, which we have argued against——

Chairman STARK. Oh, I see.

Mr. TRESNOWSKI [continuing]. Before the Congress for a very long time.

Chairman STARK. I guess I see where you are going and I would assure you that we had not thought of that, because not everyone has a premium. If you are saying you are afraid of a premium tax, I am suggesting to you that, from the standpoint that I look at it, it is not universal. The income tax is.

You therefore would opt out anybody. A wealthy individual, for instance, could self-insure, not pay a premium and not pay anything into the system. So that while I understand your concerns, I do not think in reality it is something this committee would look at.

Mr. TRESNOWSKI. I think those subtleties need to be looked at. I think if it is just a matter of dollars, the surcharge is cleaner. It is clearer and you would have to consider it every year.

Chairman STARK. Let me ask you this. It is my understanding that you cover about 45 percent of the 31 million Medicare beneficiaries.

Mr. TRESNOWSKI. That's approximately right, yes.

Chairman STARK. And do you have any sense—as we said earlier, there is something like an aggregate exposure out there for total medical costs to these 30 million people of let us say in the neighborhood of \$60 billion. Does that sound like a reasonable ball park——

Mr. TRESNOWSKI. That sounds reasonable.

Chairman STARK. Let us say you are then looking at 15 million people that you cover, and they may have to spend as much as \$30 billion in a year.

What do you see as your worst case scenario? What do you think you cover in terms of if every one of the 15 million people went to the max, how much of that could be covered?

Mr. TRESNOWSKI. You are talking about with our medigap policies as they are now.

Chairman STARK. Yes.

Mr. TRESNOWSKI. That \$30 billion that——

Chairman STARK. Yes, what is your worst case——

Mr. TRESNOWSKI. It is probably \$2 billion.

Chairman STARK. I guess my next question is, that if we take a little bit of that \$2 billion away, well, actually only a billion because that is about all our benefits are going to cover, there is still a large universe out there of uncovered risk for you all to fill the gaps.

Mr. TRESNOWSKI. Yes, but think about what that risk is.

Chairman STARK. Right.

Mr. TRESNOWSKI. That risk is primarily long-term care. To a modest extent, it is drugs and dental and some hearing, but the major thrust of that is long-term care. When they talk about the 50 percent out-of-pocket, that is—

Chairman STARK. If you are talking about long-term care, it is my understanding that for those people, you mean strictly medically related long-term care and not rest home, nursing home care.

Mr. TRESNOWSKI. No, I think it is that too. It is noncustodial.

Chairman STARK. OK. That is what I am asking. But you are also including the rest home type care in your estimate of—

Mr. TRESNOWSKI. It is in that \$30 billion.

Chairman STARK. And I would argue strongly with you that that is not necessarily a health or medical risk; that's a social risk. If you have got 15 million Americans with incomes of less than \$10,000, they cannot live very well anywhere. They cannot buy decent food and shelter on that kind of income. You have got 7 or 8 million of them with incomes of less than \$6,000. I think we both agree that whether they are in a nursing home or on the streets, the nursing home is just not even in the ball park, nor is the cost.

So I tend to think that this committee and the Medicare system cannot even begin to address that. I think that society should, and I would like to work at that, but I do not think we could even come close within the limits of the payroll tax.

Mr. TRESNOWSKI. I am not suggesting that, and as we address the long-term care problem, I do not disagree that it is a social problem. However, I think it is also a medical problem because you are talking about chronic illness that is not covered under the definitions of skilled nursing. And if you go into nursing homes, you see significant medical problems, deterioration, mentally, physically and otherwise, and the question is not—

Chairman STARK. But deterioration I can understand.

Mr. TRESNOWSKI. It is significant. I do not think we are suggesting that when we address the long-term care problem we are throwing the burden to the Government. If you want to get into that discussion, I could tell you how I think we could share that responsibility and move forward.

We have done some very extensive analysis of what the long-term care market opportunity is, and it is significant. There is a big market out there to purchase long-term care. But there are some very significant actuarial issues that have to be addressed. There are some incentives in terms of what Government can do, for example, in the tax treatment of reserves and so on.

Chairman STARK. Let me yield for a moment to Mr. Daub.

Mr. DAUB. I appreciate the opportunity to do this because I have to go make a 1 minute speech on the untimely passing of our State senior senator.

I need to remind my good friend from Blue Cross/Blue Shield that I am very anxious for some substantial amount of endeavor to be made on the poor performer categorization of one of the members of the Blue network in Des Moines, Iowa, and that is a part B problem and a part A problem with respect to one of the Blue's problems in Omaha.

Mr. TRESNOWSKI. Yes.

Mr. DAUB. I do not want to say in less than uncertain terms how very anxious I am for the performance standards of those two institutions to improve over the next several months. I know that an effort is being made in that regard and that you are aware of it, and I do not really need to ask any question in that regard. I just want to make myself perfectly clear.

Mr. TRESNOWSKI. I understand.

Mr. DAUB. Now I am appreciative of your testimony and the caveats you attach to the approach that the committee is taking to try to do something about the need for acute-care catastrophic protection. I personally think if we do it, it ought to be income-related, and I am much happier with your suggestion than I would be from taxing, and that is what we have to face; it is a tax. It is a new tax.

Mr. TRESNOWSKI. That is right.

Mr. DAUB. And we are doing something we said we would never do in tax reform, and that was tax a fringe benefit, a health benefit. We said we would avoid doing either. It could lead to other serious policy implications. So I appreciate your testimony in that regard.

I would say to my friend from the insurance industry, I note for my colleagues that in our file of materials is a report on medigap insurance policy ownership and experience prepared by Market Facts, Inc. It is a very substantial document. I have not yet had a chance to read it. I look forward to reading it.

I appreciate as well your testimony, because what I am worried about—in perception, if not in fact, that what we are doing after a Rose Garden bill signing ceremony will not amount to anymore but compounding a felony. People will still misunderstand their coverage. They still will not have any—when they wake up and get their bill and find out what their reimbursement is—feeling that we did anything when we get all done. And we will have said to the insurance industry that as much as we have been pounding on you to get a long-term health care system for America in place, you are now going to be even further off from wanting to do that because we have made one more step by government into the arena where you might see a possibility of making some money and doing some good.

So I do worry about it and I am hesitant and I like the thought of concentrating some of our revenue and some of our effort on figuring out what we can do about nursing home care and long-term care, if we are going to talk about catastrophic. So I thought both your statements were on point. It is not going to be an easy assignment for Chairman Stark or Vice Chairman Gradison to lead our subcommittee into a consensus. But I want you to know that I feel comfortable with what they are doing. They are working very hard to put a consensus together so that we can proceed to deal with the poor and the near-poor and do something about catastrophic.

I do not think it is appropriate to do much on acute-care. I think we should be dealing more with long-term catastrophic coverage and I appreciate that fact, too. But the realities of this place may dictate a different set of choices. Perhaps the legislation as it is put together will be broader, thanks to your testimony, than it might have been otherwise.

Thank you, Mr. Chairman.

Mr. MOOREFIELD. Mr. Chairman, may I just respond?

Chairman STARK. Sure.

Mr. MOOREFIELD. Mr. Daub, I appreciate the comment and I think the committee is aware, but I would like to make something indelible from their mind. Five years ago our industry would not have touched the field of long-term care, except for one or two companies who were experimenting, out in California primarily, Mr. Chairman. Now we know of at least 16 companies who in the last couple of years, at the urging of the association, are now experimenting with a long-term care policy. True, it is an indemnity policy. That can be improved upon if the right environment exists and if the market can be identified, as Mr. Gregg had said earlier.

We have hopes. We are a resilient industry and when we see a problem the industry moves to work on it.

Similarly, now that we have redefined what catastrophic is, the companies are already responding. We know that over 85 percent of the qualified medigap policies being issued today provide unlimited hospital days at 100 percent of cost.

Chairman STARK. What percentage, Mr. Moorefield, provide unequivocally insuring preexisting conditions?

Mr. MOOREFIELD. Preexisting conditions? I would not say many, sir.

Chairman STARK. Exactly, and that is the difference. Mine does and yours does not.

Mr. MOOREFIELD. Bernie has an open enrollment period.

Chairman STARK. Basically there is a difference.

Mr. MOOREFIELD. That is right.

Chairman STARK. None of ours is age-related and none of ours kicks out preexisting conditions, and the only way we can do that is through complete coverage. The difference basically is that there is no way that a private insurance company can provide the coverage that the Federal Government can and we can have full coverage.

So we should not be suggesting for a minute, there is enough for everybody to do. We do not have enough money and you do not have enough coverage to have run out of the last prospect. When we are up dealing with the last prospect, each of us, then we might have some argument. But I—

Mr. MOOREFIELD. I would just suggest a partial answer to you.

Chairman STARK. Let me come back because I want to talk to you in a minute.

I just wanted to go back to Mr. Tresnowski and emphasize that in no way really are we taxing private fringe benefits, or private benefits.

Mr. TRESNOWSKI. I understand.

Chairman STARK. I mean that because a lot of people share this concern. This is a value of something that the Federal Government provided earlier on in terms of a tax subsidy because of the deductibility of part of the premium paid.

Mr. TRESNOWSKI. I understand.

Chairman STARK. And I think that is very important. Now I think that last year's tax reform showed pretty clearly that this Congress and future Congresses are not going to be inclined to go

after much more of the fringe benefits. The concern of most members of this subcommittee was finding a way to income-relate, how we spread the burden of these costs. And if we could just assuage the fears that some people have that this is going to lead undoubtedly down the path of taxing a lot of benefits, I think we would make a lot of people happier.

Now having said that, I am not sure everybody will believe it. I am sure we are going to hear more of that later on today.

Mr. TRESNOWSKI. I am delighted.

Chairman STARK. Mr. Moorefield, I did not mean to interrupt you.

In your testimony you refer to a study. And if I could find that page again, your study deals with 11 top commercial medigap carriers. Could you identify which ones those are for me?

Mr. MOOREFIELD. I can identify the majority.

Chairman STARK. OK.

Mr. MOOREFIELD. Give me a moment, yes. In alphabetical order.

Chairman STARK. OK.

Mr. MOOREFIELD. They are Bankers Life & Casualty.

Chairman STARK. OK.

Mr. MOOREFIELD. Globe Life & Accident.

Chairman STARK. OK.

Mr. MOOREFIELD. Mutual of Omaha.

Chairman STARK. All right.

Mr. MOOREFIELD. National Foundation Life.

Chairman STARK. Wait a minute. I cannot find that one on my list, but I will—oh, got them, OK.

Mr. MOOREFIELD. National Home Life.

Chairman STARK. All right.

Mr. MOOREFIELD. Prudential.

Chairman STARK. OK.

Mr. MOOREFIELD. Pyramid Life.

Chairman STARK. OK.

Mr. MOOREFIELD. Reserve Life.

Chairman STARK. OK.

Mr. MOOREFIELD. Standard Life & Accident.

Chairman STARK. All right.

Mr. MOOREFIELD. And United American.

Chairman STARK. OK. Well, if you take Pru out of there, you are down to 41 percent, right?

Mr. MOOREFIELD. I do not have the percentages.

Chairman STARK. If the Blues have 45 to 50—I do not know what you figure—and Pru has 10, then—and you are talking about another 41, that is 96 percent. Then I do not know what happens to all these other poor folks down the line here. But that explains, I guess, where your study is coming from.

Mr. TRESNOWSKI. I would not call them poor folks.

Chairman STARK. Your study shows that these companies had unlimited coverage for part B expenses. So there is no cap on part B, you are suggesting, in 92 percent of those policies.

Mr. MOOREFIELD. Right.

Chairman STARK. And again, but you do not know how many of them would have open enrollment outside of the Blues—

Mr. MOOREFIELD. Open enrollment or pre-existing. Under Baucus, of course, if you are going to a qualified plan, there is a 6 months maximum waiting period.

Chairman STARK. Right.

Mr. MOOREFIELD. But that is only a partial answer to you, sir. We talked earlier about the uninsurable state pools, or the high-risk pools. That is another way which we are trying to advance.

Chairman STARK. Do you support that?

Mr. MOOREFIELD. Oh, we support it, sir. We supported you last year.

Chairman STARK. I wish you would talk to the U.S. Chamber of Commerce.

Mr. MOOREFIELD. Well, we are, we are.

Chairman STARK. You guys ought to—

Mr. MOOREFIELD. We are supporting you, sir, and talking to the Business Roundtable as well. I am just reminded that is another way we can get people in.

Chairman STARK. OK. It is true that we, we being the Federal Government, really created the medigap market for your association, isn't it?

Mr. MOOREFIELD. Yes, sir.

Chairman STARK. And I do not expect you to say any more than thank you. Your premiums are running, I do not know, well, what, \$500, \$600, \$700 million a year, a billion, I do not know. Maybe if I added them all up, it might be more than that. I cannot believe that there is not going to be a thousand areas to cover and that you guys will not think of it.

Let me just stop for a moment and talk about the confusion. One of the things that I think that Secretary Bowen's plan and/or Stark-Gradison, if I can reclaim my top billing, would attempt to do is come pretty close to taking the confusion out.

What I would like to be able to say to a senior is that if you are eligible for Medicare and you enter the hospital, the most it can cost you for a hospital bill is \$500 and change period. You cannot spend more than the \$520, and I think we come pretty close to that.

Right now you cannot say that. The confusion exists here because I have to look at a chart, but the first 60 days is \$492, the 61st to the 90th is \$123 a day. You all know the litany.

OK, by the same token I think we could say—and one of the reasons we cannot is because of the greedy physicians in the world—we could have mandatory assignment or a little more participation. If you go to the doctor, or if the doctor operates on you, you cannot spend more than \$1,000 for your 20 percent copay. If you go to a participating physician, that is it.

Now that is pretty simple, and that would probably take Danny Thomas and Loren Greene right off the night screen. And I do not know how much simpler you could get. It would not let the unscrupulous members or people who were no longer in your association flim-flam seniors or scare them.

And would not there still be tremendous amounts of opportunity for insurers to provide coverage for such items as pharmaceuticals, skilled nursing or home care—all the things that we just do not have the money to provide? We might like to, but the realities of

our budget constraints over the next ten years are going to be that there is no way we can pick up all of that.

Can't the insurance industry expand their market by ten times ten if we just fill in these gaps to begin with?

Mr. TRESNOWSKI. Can you tell me what is left? Let us just take the Stark-Gradison proposal. Let us just see what market is left. You have got the hospital deductible and you have got the stop loss on the part B side, whatever that happens to be.

Chairman STARK. Is that a big market?

Mr. TRESNOWSKI. No.

Chairman STARK. No?

Mr. TRESNOWSKI. It's a small market.

Chairman STARK. OK.

Mr. TRESNOWSKI. Then you have the drug market, which we have been in for a long time. It is a very difficult market because of the adverse selection that goes on. People buy drug benefits because they need drug benefits.

Chairman STARK. Would you rather have me take that and you guys take the part B?

Mr. TRESNOWSKI. The drug benefit?

Chairman STARK. Yeah. We will take the drug benefit, and you take part B.

Mr. TRESNOWSKI. Do you want to make a trade?

Chairman STARK. I do not know. [Laughter.]

Mr. TRESNOWSKI. Going once. [Laughter.]

And then you have got some smaller things like hearing and dental and that sort of thing.

Chairman STARK. Eye glasses.

Mr. TRESNOWSKI. Eye glasses and that sort of thing which are very small. Your big one is your long-term care. Now long-term care, do not misunderstand, is not nursing home care alone; it is also home health.

Our research in long-term care tells us the buying public would rather have home health benefits, because they want to stay home. They do not want to have a benefit where their kids can easily push them off into a nursing home. They want to be taken care of in the home.

Chairman STARK. Just one minute. As I understand it, you have got a 60-day waiting period at 90 bucks a day? Now if I add that up, that is \$5,400, is it not? That is a hell of a deductible.

Mr. TRESNOWSKI. Yes,

Chairman STARK. And I guess what I have heard is that if we would do it federally, I mean just to get an aggregate amount here, if you eliminate the first 90 days as the coinsurance, most people will die, and you have a very small population that needs this care after 90 days and makes it.

Mr. TRESNOWSKI. Those are not the products that we are going into the market with. The products that we would go into the market with are an indemnity coverage, a managed care coverage or an insurance-type like a universal life program where you would buy life coverage and be able to use it for long-term care.

Chairman STARK. You are not worried about people cheating you on home health care.

Mr. TRESNOWSKI. Well, you would have to design what benefits you apply the indemnity or the managed care to, the managed care particularly, a very critical part of that would be a range of benefits so that you could move people from one modality of care to another which is better for them, less expensive and so on. These are very, very tough issues.

As I said, our actuarial studies tell us that you have got a lot of antiselection in long-term care. You have got the moral hazard of once coverage is there, it is used. You have got the unknown as to what will be the utilization over the future period, because you are talking about the future here. Further, there is unknown with regard to how much money you are going to need because you do not know what interest rates are going to be. You do not know whether reserves are going to be taxed, or what tax rates are going to be. There are a whole lot of things in the long-term care market that are very, very iffy.

I am not saying they cannot be resolved. I am just simply saying that as we are looking at that market.

Chairman STARK. Have you any kind of idea of what income class would qualify to pay for this?

Mr. TRESNOWSKI. It is less, Mr. Stark, the income class than it is an age group. This is where I think the partnership between government and the private sector makes a big difference.

There is no way that private sector can take care of the poor, because they cannot afford protection.

Chairman STARK. How much—

Mr. TRESNOWSKI. Let me finish.

Chairman STARK. OK.

Mr. TRESNOWSKI. So far that segment of the population, just as you are faced with Medicare, at some point the Government is going to have to step up to that; liberalize Medicaid, do some things there.

There is also the old, old. When you get past 75 and 80, clearly the private sector cannot write a policy that they can afford. So somebody, the Government, is going to have to take care of them. You might say that that will automatically work itself out. It may, but it will take 20 years for it to happen.

The private sector is going to be left with a population say from 50 years old to 65 years old. Our research tells us that there is a big demand in that age group at premiums that are affordable; level premiums that stay level over that period of time.

Now that is what we think is the target opportunity.

Chairman STARK. Could you quantify that a little? When you say there is a big demand, does that deal with 20 or 30 percent of the people?

Mr. TRESNOWSKI. Sixty-five percent demand.

Chairman STARK. Sixty-five percent of the people between 50 and 65—

Mr. TRESNOWSKI. Fifty to 65 would buy a long-term care product.

Chairman STARK. And can afford it?

Mr. TRESNOWSKI. And can afford it.

Chairman STARK. And it would cover them.

Mr. TRESNOWSKI. Yes. It is very significant. If, of course, we could settle some of these actuarial questions that I raised.

Mr. MOOREFIELD. And we have one of our companies, as you probably are aware, up in Connecticut that is already offering a policy to their employees.

Chairman STARK. Is that not the one with the high entrance fee? You have got to go either 90 days at \$60 or 60 days at \$90?

Mr. MOOREFIELD. No, there are policies that have a 90 day waiver, but there are some that have only 7 days, or just 3 days in the hospital, and a couple now we know of do not have any waits at all. They will pay on a doctor's certification.

So as we see more of the experimentation, you are going to see the better products roll out, and it is not going to be long. It is not just going to be an indemnity policy as we know it today. It is going to be, as Bernie said, a combination of life care product with a payout.

Chairman STARK. We heard from Secretary Bowen that he thinks the Federal Government could provide this if we had some kind of definition as to who really has a medically related need for the long-term care. What you have got to avoid are guys like me who will quit supporting their mom and dump them on the Government. If the Government would give me 22 grand a year to put my mother in a nursing home, that would give me \$10,000 a year that I now pay to let her live in abject luxury and I go buy a condo at Ocean City with it. And I have a hunch there may be others out there as greedy as me. And that is everybody's worry, are they going to game us.

Is there such a demand for comfortable living, and then the nursing home developers——

Mr. TRESNOWSKI. That is why the design of the benefit becomes so important. You have to emphasize and put incentives on home health services.

Chairman STARK. Mr. Gregg.

Mr. GREGG. I would like to follow up on that.

You have described several actuarial roadblocks to long-term insurance. Are any of these roadblocks items that the Government could address——

Mr. TRESNOWSKI. Yes.

Mr. GREGG [continuing]. To make long-term insurance?

Mr. TRESNOWSKI. Yes. And the most important would be the reserve build up for these programs to give some assurance that what the tax policy would be with regard to the build up of those reserves.

Mr. MOOREFIELD. Life reserves under the life——

Mr. TRESNOWSKI. Yes, that is exactly right, because that makes a very big difference in terms of the money that is available, and thus the premium that would be charged. In fact, that was one of Secretary Bowen's recommendations in this report.

Mr. MOOREFIELD. Yes.

Mr. GREGG. I do not know a great deal about the insurance tax law, and I am sitting with the chairman who writes insurance tax law. Is that a viable request? I mean how much does that cost us?

Mr. TRESNOWSKI. Well, it is not going to cost you anything because there are not reserves there right now.

Mr. GREGG. Is there any way we can get the thing rolling?

Mr. TRESNOWSKI. Well, I do not know the price number, but it is certainly something that Congress should consider.

Mr. GREGG. Would that create a greater incentive to go into this—

Mr. TRESNOWSKI. Oh, yes, indeed.

Chairman STARK. Is that some kind of inside build up exemption?

Mr. MOOREFIELD. Yes, right.

Mr. TRESNOWSKI. Like life insurance.

Chairman STARK. It is a question then whether we pay the money through the Tax Code or through a trust fund that we finance through payroll tax or others. I mean it is—

Mr. MOOREFIELD. It is not money you are getting now because there is no reserves here for it. So it is a question of lost future revenue, if you would, if you—

Chairman STARK. Yes.

Mr. GREGG. Are there any other items?

Mr. MOOREFIELD. Yes. Under the DEFRA a couple years back, you removed the incentives for the employer to prefund folks' retirement health benefits. And the Secretary's advisory committee and the President have all recommended that that be reviewed because it is a tax policy question. Employers would have at least a choice to offer an option of long-term care and other benefits for the retired employees.

About 30 percent of those we include in medigap covered people are under group plans now, but those plans are getting very costly, as you see in the paper every day. There is more and more doubt about them.

So allowing them to prefund would be most encouraging, for long-term care as well as providing extended health coverage for the over age 65.

Mr. GREGG. If we were to include in the Stark-Gradison bill a series of incentives which would take out some of these actuarial variables, the ones that we could address as the Government, are the other actuarial roadblocks so great that you are not going to get any movement in this area anyway?

Mr. TRESNOWSKI. That is hard to answer, and it is a very good question. It is hard to answer because one does not know what selection you would find. If you targeted your market to the 50- to 65-year-old, you probably would not get a lot of selection, because generally that population is not in immediate need of long-term care. They would be anticipating something for the future.

The other one having to do with utilization projections, interest rates, you build assumptions in. It would depend on what all those assumptions lead to in terms of a premium and whether that is marketable.

I do not think they represent major barriers though. I think that the two things we have identified that the Government could do would go a long way to encouraging the private sector to move aggressively into this market.

I can tell you from the standpoint of Blue Cross/Blue Shield, we have studied this now for 2 years in great depth, and we have two of our member plans that are now piloting long-term care products.

We need to find out just exactly what does happen in the marketplace rather than just some kind of market research type thing.

But to answer your question directly, I think they would be good incentives for us.

Mr. MOOREFIELD. We have data through HCFA and other sources on convalescent nursing home care, so you can project on that; you know what that is. It is on the intermediate care that there is very, very little data anyplace, except what we are now starting to build up in these last 2, 3 years. It will take 5 or 10 years to get some good data on intermediate type basis. But once you get that, then you can make judgments—we do know that 50 percent of the people who go into nursing homes are out within 9 months, and about 93 percent of them are out within 5 years, one way or another, or dead. But those are figures which are just now starting to come to us. Those would be helpful.

Going back to Mr. Stark's and Mr. Gradison's proposal on unlimited hospital benefits, we know there are only 2,000 people that exhaust that 150-day Medicare hospital benefit. That is the reason it is easy for an insurance company with that data to come forward and offer unlimited hospital days, or 365 days, if that sounds better.

Chairman STARK. Gentlemen, thank you very much. We will look forward to working with you in the months ahead as we proceed.

If you are interested in this morning's sessions, do not miss this afternoon's sessions. They will be exciting and new. We will reconvene in room 1100 at 1 p.m.

Mr. TRESNOWSKI. Thank you, Mr. Chairman.

[Recess.]

AFTERNOON SESSION

Chairman STARK. The committee will reconvene, and we will hear from the Honorable Don Bonker, our colleague from the great State of Washington.

Don, welcome to the committee. It is my understanding you are going to testify on H.R. 784, and without objection, your prepared testimony and any supplemental material you may have in explanation of H.R. 784 will be made part of the record. And you may proceed to expand on your testimony or explain to us in any manner you are comfortable.

STATEMENT OF HON. DON BONKER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON, AND CHAIRMAN, SUBCOMMITTEE ON HOUSING AND CONSUMER INTERESTS, SELECT COMMITTEE ON AGING

Mr. BONKER. Thank you, Mr. Chairman, for allowing me to testify on short notice. And I do have a statement that I will submit for the record.

Mr. Chairman, my committee staff has prepared an analysis of your legislation—H.R. 1281, H.R. 1280—Secretary Bowen's proposal, and the proposal I have introduced. This is the third session of Congress that I have sponsored this bill.

Chairman STARK. Did your staff determine that yours is the best?

Mr. BONKER. I did not say that, Mr. Chairman. I would never say that before your committee.

The comparison is there, and I would like to have you look at it because I think we are all trying to deal with the same problem; it is only a difference in approach.

Secretary Bowen appeared before the Select Committee on Aging last month, and while the Reagan administration proposal certainly is bold, I would have to agree with Senator Heinz' characterization that it is like a hospital gown. It is short, covers your front, but leaves your you-know-what exposed. At least we now have the issue on the table, and with your proposal and others, hopefully this Congress will deal effectively with the problem of catastrophic illness.

Mr. Chairman, I was working on the Senate Select Committee on Aging staff in 1964, the landmark year in which the Congress enacted Medicare. At that time Medicare was proclaimed the answer to health care coverage for senior citizens. It was originally intended to cover 80 percent of all the health needs of older Americans.

In 1987, we find that Medicare covers only 48 percent of health costs. Therefore, seniors have to purchase supplemental insurance, and even with additional coverage, they still have to dig into their pockets which has made it very expensive for them.

I have approached this issue not necessarily in terms of the exorbitant costs associated with catastrophic illness, but instead in terms of medigap coverage. Interestingly, our proposals are very similar in terms of coverage. We both attempt to expand Medicare, to give senior citizens a broader range of coverage than they are presently getting.

Medigap insurance is a problem I hope the committee will address in the course of its work on the pending legislation. As you know, the GAO, in its report to your subcommittee last October, stated that older Americans got back only 60 cents per \$1 in premiums paid for commercial health insurance. That compares unfavorably with most health policies sold by large businesses where the average is 90 percent or 90 cents benefit for every one dollar paid in premium.

Mr. Chairman, as long as we compel senior citizens to buy supplemental insurance, we are going to have some serious gaps in coverage. That is where we have a similar purpose.

My proposal attempts to replace private medigap insurance with expanded Medicare coverage, making up the difference through optional increased premium payments. For \$20 per month additional premium, a senior citizen would not have to purchase additional private medigap insurance.

Now, this is actuarially sound. It was developed by a former Administrator of HCFA. It provides expanded insurance coverage and not only would seniors no longer have to purchase additional insurance, they would be spared all that paperwork that sometimes is more painful than the illness itself.

Lastly, for an additional \$6.60-\$10 per month, a senior could qualify for full coverage of prescription drugs used in the treatment of chronic illness.

Mr. Chairman, insofar as I know, your proposal implies coverage of what is now being provided by medigap insurers. Seniors should

not have to pay more, in whatever form, either through premium increases or through taxation of benefits, and then still need to purchase medigap insurance. So, I would make just two suggestions, if I could be presumptuous enough, Mr. Chairman.

The first is that you might consider allowing seniors to opt for expanded coverage through paying additional premiums increasing from what is now \$15.50, to \$35.50. Then they would not be forced to purchase medigap insurance. Second, you might consider tacking on the additional \$6.60-\$10 per month option that would enable full coverage for prescription drugs used in the treatment of chronic illnesses.

I think this is a sound approach to ease the financial problems faced by senior citizens in meeting their basic needs

Thank you, Mr. Chairman.

[The prepared statement follows:]

TESTIMONY OF DON BONKER
CHAIRMAN
SUBCOMMITTEE ON HOUSING AND CONSUMER INTERESTS
SELECT COMMITTEE ON AGING

Thank you for the opportunity to testify before you today on H.R. 784, legislation I have introduced that would improve Medicare, by offering two additional supplemental medical insurance options. I have introduced this legislation in each of the two previous Congresses.

I commend the efforts of Chairman Stark and Ranking Member Gradison in developing the Medicare Catastrophic Protection Acts of 1987 (H.R.1280 and H.R. 1281). I certainly share your concerns on this issue and am pleased to see that our bills are similar in many respects. I hope that we can work together to ensure the needs of this nation's elderly — whose out-of-pocket health costs continue to increase dramatically — are being met.

Secretary Bowen's report to the President on catastrophic coverage has certainly brought this issue to the forefront. While I applaud the Administration's proposal, the White House does not go far enough. Under this plan, seniors would still have to pay up to \$2000 in out-of-pocket expenses each year before the President's catastrophic coverage would kick in. Additionally, such vital benefits as outpatient drugs, home health and nursing home care are not covered.

Currently, about two thirds of Medicare beneficiaries have enrolled in private "Medigap" insurance. Although these supplemental insurance programs have helped, the cost of this protection is often very high and the extent of coverage can vary tremendously. Too often, such insurance fails to go beyond existing Medicare coverage — it just picks up deductibles and copayments.

Not only do Medicare beneficiaries get short-changed from the government and private insurers, they have to deal with the vexing paperwork, which is often more painful than the illness itself.

My legislation is far more comprehensive than the Administration's plan and would provide our nation's elderly with real security from the threat of devastating medical costs.

My bill would offer beneficiaries the option of receiving more comprehensive coverage by paying an additional monthly premium. First, each individual that chooses to enroll in the SMI, or Part B program, would be given the opportunity to voluntarily select additional insurance coverage for most costsharing requirements under both Parts A and B. This federal "Medigap" coverage would include all but the first hospital deductible in a given year, all copayments for hospital care above the 60th day, and all hospital care beyond the 60th life-time day. All complicated spell of illness requirements would be eliminated. In addition, the 20 percent Part B coinsurance requirement would be covered up to the reasonable charge level allowed by Medicare. Enrollee premiums for this optional comprehensive insurance coverage would be calculated by Medicare actuaries to reflect the actual cost of coverage. No new payroll tax or Federal general revenues would be required.

The primary advantage to the beneficiary would be the low cost of the premium, better coverage, and less confusion about their benefits. At the same time, my proposal would not add a penny to the federal deficit. If implemented immediately, the cost of the comprehensive coverage option would be about \$20.00 per month — an amount considerably lower than Medigap insurers charge for similar coverage.

The second part of this legislation would allow each individual who chooses to enroll in the SMI program a one-time opportunity to voluntarily select coverage of outpatient drugs used in the treatment of chronic illnesses. As with the first option, enrollee premiums would be calculated by the actuaries to reflect the actual cost of coverage. A restricted drug benefit formula would be developed by the Secretary of Health and Human Services, as well as a prospective payment rate, and a claims processing system in which druggists would be required to take assignment for the payment of covered drugs. This SMI drug option would afford important protection against a particularly heavy cost of long-term illnesses. We estimate that the premium would be about \$9.40 per month.

The elderly are the largest consumers of prescription drugs. Drug prices have increased at a rate twice that of other commodities included in the Consumer Price Index (CPI). For example, data from the Bureau of Labor Statistics indicate that for the period January 1981 - June 1985, the CPI rose 23 percent, while prescription drug prices jumped 56 percent.

Unlike most other health care costs, prescription drugs are not typically covered by private health insurance or by Medicare outside of the hospital. Most Medigap policies do not cover these costs, and Medicaid will only cover these costs for the indigent. Only 20 percent of the elderly fall into one of these categories, the remaining 80 percent must pay for drugs from their own pockets.

Over the past two months, major senior groups including the American Association of Retired Persons and the National Council of Senior Citizens have testified at numerous Congressional hearings on catastrophic care. They have consistently expressed their strong support for coverage of prescription drugs — my bill provides this coverage, and it is affordable.

H.R. 784 is not intended as a solution to all health care financing problems facing our nation's elderly. The cost-sharing burden placed on senior citizens under the present Medicare program is intolerable and must be removed.

Like you, Mr. Chairman, I am deeply concerned about the truly catastrophic cost of nursing home and other long-term care services. It is essential that after we have effectively covered the out-of-pocket costs that our respective bills address, we must then turn our full attention to the cost of long-term care. I look forward to continuing to work with you and the other members of the Ways and Means Committee to tackle the critical issue of long-term care coverage.

My legislation is designed to ease the financial problems faced by senior citizens in meeting their basic daily needs. It is one way that we can act to guarantee that the gains we have made will not be eroded. I urge your consideration of this measure.

Chairman STARK. Don, thank you. Great minds go in the same direction.

I have got your sheets here. I gather we do not have copies of them, and I will return them. I will not mark them up. But as near as I can tell just quickly surmising, you, Secretary Bowen, Bill Gradison and myself are all heading in the same direction. You have an extra part which would cover pharmaceutical. And if we could figure out a way to pay for it, that we could sell, I would be the first one to sign on.

But as I calculate what you have done here—and you may not want to respond to this, but your staff may—you are saying \$10 a month covers pharmaceuticals. I calculate that—if my math is right—to be \$120 a year times \$30 million, or \$3 billion 600 million. And it is my understanding that they spend about \$8 billion on drugs. So, you might want to look at that.

On the other hand, your \$20 a month at \$240 a year comes out to be \$7.2 billion. And we figure that our catastrophic cost is just a little over \$5 billion a year. So, you are two over—but maybe your benefits cost that much more.

Mr. BONKER. Let me pose a question to you. Does your proposal do away with the need for medigap insurance?

Chairman STARK. Pretty much, but not for the first \$1,500. I believe you have one payment, don't you, going in? Or you have no payments at all? You have one deductible.

Mr. BONKER. We are similar on that.

Chairman STARK. Yes, okay.

Mr. BONKER. One deductible per year.

Chairman STARK. And you have nothing for the doctors?

Mr. BONKER. Nothing for doctors.

Chairman STARK. That is probably the extra couple billion.

Mr. BONKER. Yes.

Chairman STARK. But you do not cover enough, as I see it, for pharmaceuticals.

Let us assume for a minute that that is just a question of how much money there is and how high the premium is. Let us assume for a minute that that is \$30 a month. That is \$360 a year.

Mr. BONKER. Well, it would be optional. If they wanted the coverage they are presently getting under medigap, they could opt for \$20 a month more in Medicare premiums and forego the \$40 to \$60 a month they pay for medigap.

Chairman STARK. Yes. But let's talk about the poor people. Let me just give you the demographics real quickly. A quarter of the poor, less than \$5,000 or \$6,000 a year. The next upper quarter, up to \$10,000. So, we have got half of 15 million people with less than \$10,000 income. And most of them are eligible for Medicaid. And then the next quarter you do not really get much above, say, \$20,000.

What I am suggesting to you is that we all would like to give as many benefits as we can. There might be a little bit of difference in priority whether you want to have the first day medical coverage or you would rather have pharmaceuticals or whether you want a little copay in the pharmaceuticals. I think that is a matter of detail.

The question is how you pay for it. The Stark-Gradison proposal would be 15 percent, if that is the lower tax bracket, of our actuarial value, which is \$1,800 a year, or \$270. I rather suspect that if we want to increase that—now, that is only charged to the upper third of the beneficiaries.

Mr. BONKER. Thirty-five percent.

Chairman STARK. And I would suspect that you would support some progressivity in the plan or elimination of the very lowest income people from the premium. And we could go a little higher on the upper income end.

So, what I am saying is, are not we all, going pretty much in the same direction except that the Secretary has a flat premium, as do you, and we have income related ours or taxed it? I just see that somewhere within those boundaries, we are all talking about the same thing.

I do not think any of us on this committee has any fixed in cement ideas about what the benefits ought to be. We know where the gaps are, or how we ought to pay for it except that somehow the two extremes seem to be a flat, very low premium—although Secretary Bowen's, I might point out, goes up to about \$12 a month in the third year. So, it is not just that bare bones—

Mr. BONKER. It starts at \$4.92.

Chairman STARK. Well, we do not even think it starts at \$4.92 anymore. We think recalculating it, it may be closer to \$5 or \$6—\$6 the first year, going up to \$12 or something by the third year.

Mr. BONKER. And it would still require medigap coverage. You know, as I mentioned previously, I have not come at this in terms of catastrophic illness. My interest was originally sparked a number of years ago out of concern for what Medicare was not covering, thus forcing people to purchase additional insurance. More recently, I have been going through the Medicare paperwork this last week over my father's surgery.

The approach I wanted to take was that if we could provide the same level of coverage as private insurance for \$20 additional a month, seniors would opt for that opportunity.

Chairman STARK. I think they would opt anyway. But I think to get that level, you almost have to have universal coverage. We do have that in part B anyway.

I think we are all saying the same thing.

Mr. BONKER. I think we are.

Chairman STARK. I would love to drop the total out-of-pocket cost to \$500 instead of \$1,500. But that just increases the cost. You cannot have both ends of the teeter-totter in the air at the same time.

Mr. BONKER. Well, if you do go with the taxing formula, I would hope that the committee staff could, in a report, determine what level of additional insurance would still be necessary. If you are picking up a lot of what insurance presently covers, then the premiums ought to come way down to catch what remains uncovered. Otherwise, they are going to be—at least the 35 percent of beneficiaries will be paying more into the program, but everybody will still have to buy the additional insurance.

Chairman STARK. I appreciate your interest. I know the subcommittee does. And I hope you will continue to work with us because

we hope to get something done in the next couple of months. Your interest and your participation will help us.

Mr. BONKER. Thank you, Mr. Chairman, very much.

Chairman STARK. Mr. Daub?

Mr. DAUB. Mr. Chairman, just briefly. Our colleague, Mr. Bonker, is always a thoughtful and constructive member of Congress. I know this is an area from Aging Committee work as well where you have gathered a good deal of expertise, and where you have clearly demonstrated your concern.

You essentially concluded that the government ought to take this part of our business in America and run it. Is that correct?

Mr. BONKER. I think that is the way it comes out, Mr. Daub. When Medicare was originally enacted, it was to cover 80 percent of beneficiaries' out-of-pocket medical costs, and somehow we have been slipping over the years. What I am trying to do is bring it back to its original intent.

Mr. DAUB. What was the premium for that coverage supposed to be then in 1964? Do you recall?

Mr. BONKER. Well, I believe it was only about \$5 a month but, of course, health costs have since gone way out of sight. Medicare just does not sufficiently cover what was originally intended to do. As a result, medigap has had to come in, often picking up more of the out-of-pocket costs.

You know, I remember the testimony at the time. Medicare was originally intended to cover 100 percent. But there were compromises in the course of—especially in the Senate—work on the legislation. So, it came down to 80 percent. Today, it is 48 percent. Beneficiaries pay about the same proportion of their income in out-of-pocket costs as they did before Medicare.

Mr. DAUB. What was the beneficiary premium payment for part B at the beginning? Do you remember what it was supposed to be?

Mr. BONKER. It was to be very low. It was between \$3.50 and \$5.

Mr. DAUB. Was it supposed to be 50 percent of the cost of the outlays?

Mr. BONKER. It was supposed to be 80 percent and beneficiaries were to pick up the other 20 percent of their bills.

Mr. DAUB. I am trying to get at what the burden was on the individual voluntary part B sign-up.

Mr. BONKER. Well, I think, at first, people were to pick up the 20 percent that Medicare did not cover, but over the course of time many have been compelled to purchase additional or supplemental insurance, which has now become integral to the whole program.

Mr. DAUB. I guess I do not recall exactly, but I thought that the original purpose was that the part B premium was supposed to be 50 percent of the cost of the program at that time—that the participant would pick up essentially half the cost. We are now 25 percent of the cost, as you know.

Mr. BONKER. Well, part B covers physician services—

Mr. DAUB. Yes, and other related services.

Mr. BONKER. And presently it covers—

Senator DAUB. The premium they pay is 25 percent of the total cost and the Treasury picks up 75 percent of the total cost.

Mr. BONKER. Yes, that is right.

Mr. DAUB. Wasn't the original purpose to be about 50-50?

Mr. BONKER. Now that I cannot tell you. What I can tell you is that beneficiaries were only to pick up 20 percent of their Medicare bills, at most.

Mr. DAUB. Well, I appreciate the gentleman's concern and interest, and we appreciate that he has indicated willingness to work with the committee.

Mr. BONKER. Thank you.

Chairman STARK. Thanks very much, Don.

Our next panel is representing provider groups. One member of the panel is Jack Owen, the executive vice president of the American Hospital Association. And I would like to recognize my colleague, Mr. Daub, to introduce the other member.

Mr. DAUB. Thank you very much, Mr. Chairman. It is, indeed, a distinct privilege and honor for me to introduce to you, to this committee, to those here in room 1100 of the Ways and Means full committee hearing room, Dr. Jerald R. Schenken, medical doctor, a member of the board of trustees of the American Medical Association. He is my long-time friend on whom I have relied for many, many years for specific information about health care.

In his own career specialty of pathology, he is well-known following in his father's great tradition. In that particular specialty he has contributed an immense amount of learning to his specialty within his profession. He is not only a practicing pathologist and physician, but he is a teacher, teaching young doctors their skills and providing them with his knowledge, but indeed imparting to professionals and other areas, as well as paraprofessionals, his skill and knowledge in the practice of medicine with Methodist and Children's Hospitals in Omaha, NE.

We are going to look forward to his testimony I know, and again, Mr. Chairman, it is my privilege to welcome him here for his testimony today.

Chairman STARK. All I can say is, Jack Owen, if you want to move to Oakland, you would get an introduction like that too.

But without further ado, Dr. Schenken, I would like to add my welcome to the committee. Your prepared testimony will appear in the record in its entirety. And if you would like to summarize it or add to it or explain it to us, you may proceed in any manner that you are comfortable.

STATEMENT OF JERALD R. SCHENKEN, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY ROSS RUBIN, DIRECTOR, DEPARTMENT OF FEDERAL LEGISLATION

Dr. SCHENKEN. Thank you, Mr. Chairman. In regard to the hour, I would like to be as brief as possible, if I could.

Chairman STARK. Certainly.

Dr. SCHENKEN. Mr. Chairman and members, I really do appreciate the introduction. Probably not deserved, but I appreciate it anyway.

My name is Jerald R. Schenken. I am a physician in the practice of pathology in Omaha, NE, and a member of the board of trustees of the American Medical Association. With me is Ross Rubin, director of the AMA's Department of Federal Legislation.

The AMA is pleased to have this opportunity to testify concerning the important issue of catastrophic coverage for health and long-term care needs. For many years, we have advocated that catastrophic coverage should be included as part of a package of minimum benefits for all health insurance plans. Such catastrophic coverage can often be provided at relatively small additional charge.

Mr. Chairman, we believe that ideally the addition of catastrophic coverage to current Medicare benefits should be accomplished as part of a broad reform of the Medicare program. With this in mind we have developed a proposal for financing health care services for the elderly that is fiscally sound and would provide comprehensive protection, including catastrophic coverage. A summary and a full copy of our proposal is attached.

The AMA recognizes that the catastrophic coverage issue is being addressed by Congress prior to long-term reform of the Medicare program because of the appropriate concern for the risk of catastrophic expense faced by the elderly. While we support the intent of proposals by Secretary Bowen and others to expand Medicare to provide catastrophic coverage, we believe that catastrophic coverage could be provided more efficiently and effectively by the private sector.

Currently, about 70 percent of the beneficiaries have so-called medigap policies. These policies already provide a considerable degree of catastrophic protection because they must meet the minimum standards established by existing federal law.

We recognize that gaps in medigap coverage do remain. We believe that before Federal action is undertaken, the private sector should be afforded the opportunity to close these coverage gaps and provide the benefits proposed by Secretary Bowen at a comparable cost. Already one major insurance company has reportedly stated that it could offer the benefits provided in Secretary Bowen's proposal at no additional cost.

Private insurance companies should also voluntarily expand upon and broaden Medicare benefits. For example, increased coverage could be provided for expanded skilled nursing services beyond the restrictive Medicare qualifications and could even include some intermediate care nursing services.

Innovative approaches should be explored for providing catastrophic protection for the 10 percent of the elderly who have neither medigap nor medicaid coverage. For example, vouchers could be provided to such persons to help them pay the premiums of private medigap policies that include catastrophic protection. Alternatively, Medicaid spenddown provisions could be liberalized to allow these persons to become eligible for Medicaid after they incur a specific amount of out-of-pocket costs.

If the Congress decides to provide catastrophic coverage through an expansion of the Medicare program, such coverage should be provided through some forms of means testing. Any Government funded catastrophic coverage program should also be limited to acute health care cost, otherwise the program would become much too costly. Broad personal and family responsibility for long-term care should be encouraged through appropriate tax and savings incentives.

Mr. Chairman, at this time we would like to take the opportunity to complement both you and Mr. Gradison for your proposal which appropriately reflects the needs for improved skilled nursing coverage through Medicare and would adopt the concept of means testing.

While the focus of this hearing is on providing catastrophic coverage for the elderly, the needs of the nonelderly should not be overlooked. The AMA believes that adequate health insurance, including catastrophic coverage, should be furnished in the employment setting. Such coverage can and should be encouraged by such things as limiting the deductibility of employer health insurance premiums only to employers who furnish health plans that provide such coverage and who participate in statewide risk pooling programs, which we have also encouraged.

Workers who are laid off should have the opportunity to maintain employment based health insurance for at least several months after their termination if they continue to pay the same portion of the insurance premium they have paid while employed.

Mr. Chairman, we have a whole bunch of other information in our plan. We have a lot of principles in there. But at this point I would like to stop. And I would be happy to respond to any questions you may have. And we thank you very much for the opportunity to appear.

[A report, "Proposal for Financing Health Care of the Elderly," has been retained in the committee files. The prepared statement follows:]

STATEMENT
of the
AMERICAN MEDICAL ASSOCIATION
to the
Subcommittee on Health
Committee on Ways and Means
United States House of Representatives

Presented by
Jerald R. Schenken, M.D.

RE: Catastrophic Coverage for Health and Long-Term Care Needs

March 10, 1987

Mr. Chairman and Members of the Committee:

My name is Jerald R. Schenken, M.D. I am a physician in the practice of pathology in Omaha, Nebraska, and am a member of the Board of Trustees of the American Medical Association. Accompanying me is Ross Rubin, Director of the AMA's Department of Federal Legislation.

The AMA is pleased to have this opportunity to testify concerning the important issue of catastrophic coverage for health and long-term care needs. For many years, we have advocated that catastrophic health care coverage should be included as part of a package of minimum benefits in all health insurance plans. Such catastrophic coverage can often be provided at relatively small additional cost. In addition, even though the vast majority of persons would never actually use the catastrophic benefit, its mere existence would provide vital piece of mind.

Mr. Chairman, in discussing catastrophic coverage, it is important to keep in mind that what constitutes a catastrophic expense varies from person to person -- based on individual financial resources. An expense that clearly would be catastrophic to a person relying solely on Social Security cash benefits might be manageable for an individual with a substantial annual income.

Catastrophic care expenses can be divided into two categories: acute health care costs and long-term custodial care costs. Effective steps should be taken now to assure all our citizens, including Medicare beneficiaries, that they will not become impoverished if faced with large acute health care expenses. Efforts should also be increased towards developing mechanisms to cover the potentially catastrophic expense of long-term care.

Acute Care Catastrophic Costs for the Elderly

AMA Proposal

Ideally, the addition of catastrophic coverage to current Medicare benefits should be accomplished as part of a broad reform of the Medicare program to assure its continuation. With this in mind, we have developed a new program, one that is fiscally sound and will assure health care services for the elderly well into the 21st century. Our proposal would provide comprehensive protection, including catastrophic coverage. A summary and a full copy of our proposal are attached to this statement as an appendix.

Advantages of Private Insurance

The AMA recognizes that the catastrophic coverage issue is being addressed by Congress prior to long-term reform of the Medicare program because of appropriate concern for the risk of catastrophic expense faced by the elderly. While we support the intent of proposals by Secretary Bowen and others to expand Medicare to provide catastrophic coverage, we believe that such coverage is better provided through private insurance rather than under a government program.

The AMA believes that catastrophic coverage could be provided more efficiently and effectively by the private sector. Currently, about 70% of Medicare beneficiaries have Medigap policies. These policies already provide a considerable degree of catastrophic protection because they must meet the following minimum standards as a result of Congressional mandate:

- coverage of Part A inpatient coinsurance for Medicare eligible expenses from the 61st through 90th day of hospitalization in any "spell of illness";
- coverage of Part A inpatient coinsurance for Medicare eligible expenses incurred during use of Medicare's lifetime reserve days (91st through 150th day of hospitalization);
- upon exhaustion of all Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 90% of all Medicare Part A eligible expenses for a lifetime maximum of up to 365 days; and
- coverage of Medicare Part B coinsurance up to at least \$5,000 per year, subject to a maximum annual out-of-pocket deductible of \$200.

We recognize, however, that gaps in Medigap coverage do remain. For example, the minimum standards for Medigap policies do not require that Part A coinsurance for the 21st through the 100th day of skilled nursing facility care be covered or that such policies provide coverage beyond the 100th day of a stay. We believe that before federal action is undertaken, however, the private sector should be afforded the opportunity to close these coverage gaps and provide the benefits proposed by Secretary Bowen at a comparable cost. While some companies offer broad coverage, Congress could modify the minimum standards for all Medigap policies to require that meaningful catastrophic coverage be included.

Private insurance companies should also voluntarily expand upon and broaden Medicare benefits. For example, increased coverage could be provided for expanded skilled nursing services, beyond the restrictive Medicare qualifications and even include intermediate care nursing services. Other types of coverage beyond Medicare's strict coverage and reimbursement limits should also be offered.

Coverage for Indigent Elderly

Currently, about 20% of the elderly have neither Medigap nor Medicaid coverage. Most of these persons are poor or near-poor, but are not eligible for Medicaid. Innovative approaches should be explored for providing catastrophic protection for these persons. For example, vouchers could be provided to such persons to help them pay the premiums for private Medigap policies that include catastrophic protection. Alternatively, Medicaid's "spend down" provisions could be liberalized to allow these persons to become eligible for Medicaid after they incur a specified amount of out-of-pocket costs.

In any event, in order to provide coverage for this group, some financial assistance is necessary.

Imposing an additional Part B premium may force some beneficiaries out of the Part B program, exposing this vulnerable population to increased risk. It would be more equitable to provide assistance through a means-tested combined catastrophic and basic Part B premium.

Government-Funded Program

If Congress decides to provide catastrophic coverage through an expansion of the Medicare program, such coverage should be limited to acute health care costs. Otherwise the program would become much too costly. In addition, any government-funded catastrophic coverage program should provide some form of means-testing.

Mr. Chairman, we would like to take this opportunity to compliment you and Mr. Gradison on your proposal which appropriately reflects the need for improved skilled nursing coverage under Medicare and, through the taxing of a portion of the actuarial value of Part A and B benefits, would adopt the concept of means-testing.

Long-Term Care Catastrophic Expenses for the Elderly

The great area of uncertainty concerning catastrophic insurance is the extent, if any, to which such coverage should include long-term custodial care. The average cost of nursing home care is about \$22,000 per year. As a result, such care often generates catastrophic expenses. As noted above, we do not favor inclusion of coverage for custodial services in a government-funded health program. We are particularly concerned that the 60% to 80% of the long-term care now provided to the disabled elderly by spouses, other relatives and/or friends would be shifted to taxpayers.

Broad personal and family responsibility for long-term care should be encouraged through appropriate tax and savings incentives. Like Secretary Bowen, we believe that personal savings for long-term care should be encouraged by permitting tax deductible contributions to an Individual Medical Account and by allowing tax-free withdrawal of Individual Retirement Account funds for any long-term care expense. We also support the principle of a refundable tax credit for long-term care insurance premiums in order to stimulate the private market for long-term care. Other tax incentives should be explored to encourage family responsibility for meeting long-term care needs. In addition, barriers to prefunding long-term care benefits provided by employers to retirees should be removed. Finally, we believe that the federal government and the private sector should work together to educate the public concerning the absence of coverage for long-term care under Medicare and Medigap policies.

Catastrophic Coverage for the Non-Elderly

While the focus of this hearing is on providing catastrophic coverage for the elderly, the needs of the non-elderly should not be overlooked.

The AMA believes that adequate health insurance, including catastrophic coverage, should be furnished in the employment setting. Such coverage can and should be encouraged by limiting the deductibility of employer health insurance premiums only to employers who furnish health plans that provide such coverage and who participate in a statewide risk pooling program. Risk pools can make basic health insurance (including catastrophic coverage) available, at reasonable cost, for persons who are uninsured, underinsured or uninsurable. Risk pools have been enacted in twelve states.

The current exclusion under the Employee Retirement Income Security Act (ERISA) of self-insured companies from state regulation has created an insurmountable impediment to the establishment of effective state risk pools. We strongly urge appropriate amendments to ERISA that would allow states to regulate self-insured health plans for the purpose of requiring them to comply with state laws, including those requiring risk pools.

Workers who are laid off should have the opportunity to maintain employment-based health insurance for at least several months after their termination if they continue to pay the same portion of the insurance premium they paid while employed. In addition, we support the recently enacted legislation that requires employers to make group rate coverage available for terminated workers at the worker's sole expense for an additional 18 months.

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Conclusion

The AMA believes that providing coverage for catastrophic acute care costs can be achieved at small additional cost and should be aggressively pursued. We believe that such coverage can be provided more comprehensively by the private sector than under the expanded Medicare proposals. If Congress decides, however, to provide catastrophic coverage through Medicare, such a program should be limited to acute health care costs and should provide some form of means-testing. We believe that broad personal and family responsibility for long-term care should be encouraged through appropriate tax and savings incentives.

Mr. Chairman, I will be happy to answer any questions Members of the Committee may have.

Chairman STARK. Thank you, Doctor.
Mr. Owen?

**STATEMENT OF JACK W. OWEN, EXECUTIVE VICE PRESIDENT,
AMERICAN HOSPITAL ASSOCIATION**

Mr. OWEN. Thank you, Mr. Chairman, Congressman Daub.

My name is Jack Owen. I am the executive vice president of the American Hospital Association and director of the Washington office of the American Hospital Association.

In my 5 years here in Washington, it is heartening to see the increased level of debate and interest in long-term care, catastrophic and care for the indigent. You and other cosponsors are to be commended in what we think is a first step. Long-term care is still another problem that is to be considered at another time.

What I would like to do is to use my time by just going through some of the things that we think might be some additions or that might be considered in this legislation in addition to what you already have in the legislation. I see my time is—really cut very short. So, I will try to talk as fast as possible.

Chairman STARK. You are not in overtime. That is OK.

Mr. OWEN. First of all, on the covered services, the American Hospital Association supports the elimination of acute inpatient hospital day limits and the restructuring of copayments and deductibles to make the benefit package less complex and more understandable. We think you have done a good job in doing that.

We would recommend you think about some expansions of acute care benefits to reflect the changing patterns of health care delivery, if at all possible. Let me go through just a couple of those.

The Medicare benefit was structured around the belief that most acute care occurred in inpatient hospital settings. And this is no longer entirely true. Services that are not covered at all by Medicare, such as prescription drugs provided to non-inpatients have become an increasingly important part of medical expenditures of the elderly.

Now, the barrier to that, of course, has been the fear of substantial utilization and the cost increases that go along with such a coverage. We think these problems could be reduced by expanding the set of covered services to include some prescription pharmaceuticals, but limiting that coverage with an annual deductible and copayments until the annual out-of-pocket is reached so that we do not have a runaway kind of a problem.

Second, there is an increased out-of-pocket expenditure for skilled nursing facilities, and we think the bill, H.R. 1280, expands that. And the day limit from 100 to 150 days is certainly a move in the right direction.

Third is the problem with skilled nursing in home health service for which Medicare coverage is denied. Medicare beneficiaries are often caught up in a patient absurdity of being told they are not sick enough to warrant admission to the hospital, but they are too sick to be treated at home. And they cannot be treated in a skilled nursing facility because they have not met a 3-day prior hospitalization rule. We think that should be looked at and perhaps corrected.

You will see that some of these things that I am talking about really do not help hospitals a whole lot. In fact, the costs of this program will not mean a great deal more income to hospitals. We think it is still the right way to go as far as the patients are concerned.

The elimination of the coverage on acute inpatient hospital care with the exception of the 190-day lifetime limit on psychiatric hospital care we think should be reconsidered. It is time to eliminate the 190-day limit as outmoded and unnecessary. With extensive utilization controls and cost per case limits on payment, there seems to be no basis for perpetuating a two class system of coverage for psychiatric and nonpsychiatric patients. We seem to forget that both of these are illnesses that can be taken care of and certainly can be controlled through a system such as the DRG system is now doing for the nonpsychiatric.

Methods of financing, just a couple of comments. We see that you want to use taxation of a portion of the Medicare benefit actuarial values to generate revenues which would be passed back. The advantage of the taxation approach, of course, is its sensitivity to the income of the individual beneficiaries.

It is an important advantage to 49 percent of the elderly whose annual incomes are less than \$10,000. The disadvantage that we see of the taxation approach is that it creates an arbitrary premium because the premium is the function of the current average value of Medicare benefits current tax law and current income distribution of the Medicare population, rather than a cost of the expanded benefits.

A more straightforward approach is the use of an actuarially sound premium to cover the cost of additional coverage. This advantage, of course, to the premium approach is that it is not so income sensitive, and that creates a problem. We understand that.

Just a couple of other things on technical issues. We appreciate some of the section 29(g)(5) of H.R. 1280, which requires the Secretary to take into consideration reductions in payments to hospitals. We appreciate that the proposed coverage change does not yield unintended reduction of payment to hospitals. We do think, however, that it could be tightened up a little bit since hospitals will not be involved as much as it appears.

In 1984 only an estimated 40,000 people had acute general hospital stays longer than 60 days and only 10 patients had stays that were longer than 150 days.

In conclusion, Mr. Chairman, I would say that this is certainly legislation in the right direction. We pledge our support and urge you to continue with the next steps necessary to take care of the 37 million uninsured to whom all medical care is a catastrophic problem.

Thank you.

[Statement of Mr. Owen follows:]

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STATEMENT
 OF THE
 AMERICAN HOSPITAL ASSOCIATION
 BEFORE THE
 SUBCOMMITTEE ON HEALTH
 OF THE
 COMMITTEE ON WAYS AND MEANS
 OF THE
 U.S. HOUSE OF REPRESENTATIVES
 ON
 CATASTROPHIC COVERAGE

March 10, 1987

SUMMARY

The Medicare Catastrophic Protection Acts of 1987 (H.R.1280 and H.R.1281) are an important first step in addressing the multifaceted problem of providing desperately needed relief for Americans from the fear of catastrophic illness and expense. The bills incorporate several important and significant improvements in the acute care benefit, particularly:

- o Elimination of limits and copayments on acute inpatient hospital care;
- o Expanded coverage and sorely needed changes in the structure of copayments for skilled nursing facility care;
- o Greater simplicity in Medicare cost-sharing provisions; and
- o Limits on beneficiary cost-sharing for covered services.

The American Hospital Association (AHA) urges that as you refine H.R.1280 and H.R.1281, some modest expansions and alternative approaches be considered. Specifically:

- o Expand coverage of non-inpatient services by implementing revised criteria for coverage of home health and skilled nursing services used in lieu of more expensive alternatives, and extend coverage to prescription pharmaceuticals.
- o Require that medical review criteria used to determine Medicare coverage of home health and skilled nursing facility services be written and made publicly available to promote better understanding of covered benefits and help guard against arbitrary denial of claims for covered services.
- o Eliminate the outmoded 190-day lifetime limit on inpatient psychiatric hospital services.
- o Consider combining a premium with protections for low-income beneficiaries as an alternative source of financing for the benefit expansion.

We also raise two technical issues:

- o The adjustment to hospital payment rates to reflect elimination of day limits should be clarified to ensure that it does not yield unintended reductions in hospital payments.
- o Elimination of the 210-day limit on hospice care should be carefully monitored so that it does not yield increases in cost without commensurate increases in hospice payment.

AHA pledges its support and cooperation in building on the work begun by this legislation.

INTRODUCTION

Mr. Chairman, I am Jack W. Owen, executive vice president of the American Hospital Association and director of the Washington Office. The issue of catastrophic coverage is of great concern to the Association's 5,600 member health care institutions. Over the past several years, the AHA has examined a number of alternatives for improving the Medicare benefit package, for making it more comprehensible to Medicare beneficiaries, and for ensuring the long-term fiscal soundness of the program. The AHA also has examined public- and private-sector alternatives for addressing the needs of the non-Medicare population who are medically indigent. Recognizing your desire to limit this proposal and today's discussion to Medicare acute care benefit coverage, however, our comments focus on recommendations on the issue of acute catastrophic illness for the Medicare eligible population.

Last December, the AHA had the opportunity to present to the Congress our recommendations for a comprehensive approach to catastrophic coverage addressing the needs of the elderly and non-elderly for acute and long-term care. The increased level of debate and interest that has occurred since then is heartening. You and the other cosponsors of the Medicare Catastrophic Protection Acts (H.R.1280 and H.R.1281) are to be commended for taking a first step in addressing the multifaceted problem of providing desperately needed relief for Americans from the fear of catastrophic illness and expense.

DIMENSIONS OF CATASTROPHIC ILLNESS

Each year, thousands of families face financial ruin because one of their members incurs health care expenses that are not covered by insurance and are beyond the family's ability to pay. When this happens, a serious illness --which can be a personal catastrophe--becomes a financial catastrophe for the entire family. Most Americans are protected against the cost of acute medical care through either private insurance, Medicare, or Medicaid. But, 37 million Americans face a financial catastrophe from any serious illness because they lack any form of insurance. An estimated 20 million of the non-Medicare insured population also may be at risk for catastrophic acute care because of limitations on private insurance coverage. Even in the Medicare population, a substantial amount of acute care must be paid out of pocket because of limitations on Medicare coverage. Thus, millions of families live in fear that a serious illness could be financially catastrophic.

Catastrophic expenses result from three gaps in health insurance coverage: inadequate Medicare coverage of catastrophic acute care costs; even more inadequate public and private coverage of long-term care costs; and the presence of large numbers of uninsured and underinsured in the non-Medicare population.

As currently structured, Medicare does not provide catastrophic coverage, even for acute care. Acute inpatient hospital care can cause significant out-of-pocket expenditures for a small percentage of beneficiaries. For example, a patient staying in the hospital 60 days incurs an inpatient deductible of \$520, plus 20 percent of any physician charges. The copayment totals to \$4,200 after 90 days and \$18,942 after 150 days. This does not happen very often: in any given year only 20-25 percent of Medicare enrollees require inpatient care, and less than one percent of those hospitalized in an acute general hospital stay more than 60 days. In 1984, beneficiaries incurred about \$4.8 billion dollars in first-day deductibles--accounting for

98 percent of all copays and deductibles for inpatient PPS admissions. When Part A and Part B services are considered, it has been estimated that about 8 percent of enrollees owed coinsurance and deductibles in excess \$1,024 in 1984. It should be noted, however, that new delivery patterns emphasizing outpatient care are creating new gaps between patient expenses and Medicare coverage and therefore new patterns of catastrophic expense.

Although the incidence of acute catastrophic care expense may be small, most Medicare enrollees may perceive themselves to be "at risk" because catastrophic expenditures are difficult to predict, and Medicare coverage rules are hard to understand. Most Medicare enrollees purchase supplemental or "wrap-around" coverage, perhaps perceiving it as protection against catastrophic acute care expenses or possibly as protection against long-term care costs as well. But, "wrap-around" coverage benefits are limited to Medicare-covered services, which means that even with "wrap-around" policies, most Medicare beneficiaries still run the risk of incurring catastrophic out-of-pocket acute care expenses and have almost no protection against long-term care costs.

Outpatient pharmaceuticals are another significant and growing source of out-of-pocket expenditures for the elderly, with only about 20 percent of such costs covered by any form of insurance. As more care shifts to non-institutional settings where Medicare does not cover prescription drugs, out-of-pocket expenses are increasing. Many beneficiaries find themselves choosing between spending limited resources on needed drugs or on the basic necessities of food and shelter.

Another obvious gap in the Medicare program is catastrophic coverage for the treatment of mental illness. Although approximately one fifth of the Medicare population should have such treatment (the American Psychiatric Association estimates), those with mental health problems are subject to a 50/50 copayment, and Medicare will pay no more than \$250 for outpatient care of mental or emotional disorders. Those with acute mental illnesses--episodic or chronic--require services on a recurrent or continuing basis.

Gaps in insurance coverage also exist for patients needing medical rehabilitation, whether it is the Medicare beneficiary recovering from a stroke or a young accident victim requiring extensive occupational and physical therapy.

Among Medicare beneficiaries, the leading cause of catastrophic expense is long-term care associated with chronic illness. Medicare provides little coverage for institutional long-term care, consistent with its focus on covering the cost of acute medical episodes. More than 90 percent of expenditures for long-term care now come from two sources: out-of-pocket expenditures and Medicaid. Out-of-pocket expenditures by consumers account for about 45 percent of all long-term care expenditures. Among elderly families spending more than \$2,000 in a year for medical care, 81.2 percent of the expenses are for nursing home care, compared with only 10 percent for hospital care and 5.9 percent for physician care. As a result, almost half of the 75-year-olds who enter private nursing homes are bankrupt in 13 weeks, and more than 70 percent exhaust their resources after a year. Once these catastrophic expenditures have been made, the elderly can obtain catastrophic coverage from Medicaid, but by that time the illness will have impoverished any non-institutionalized spouse or dependent, and thereby pushed more people into a state of public dependency.

This use of Medicaid as the payer of last resort for long-term care has absorbed a large and increasing proportion of Medicaid funds and put considerable pressure on funds available to support the non-Medicare poverty population. Currently, about three-fourths of all Medicaid expenditures are used to pay long-term care costs and other expenses generated by Medicare enrollees, leaving about one-fourth for the growing number of non-elderly, non-disabled poor. This conversion of Medicaid into a supplemental policy for Medicare enrollees exacerbates the third catastrophic care problem: the presence of a large and growing number of uninsured and underinsured non-elderly. For those without insurance, any significant illness is generally catastrophic, and the number of uninsured is growing. By 1985, 37 million people lacked insurance, one third of them living below the poverty level and another third below double the poverty level. This large and growing number of uninsured results from two trends: an increase in the number of people below the federal poverty level, and a simultaneous decrease

in the number of people covered by Medicaid. By 1983, Medicaid covered less than 40 percent of the poor, compared with 65 percent in 1976. For the uninsured, the most frequent cause of catastrophic illness is acute care, and even moderate expenses can be catastrophic.

The absence of insurance coverage for non-catastrophic acute care may actually increase the likelihood of catastrophic illness. For example, many studies have shown that lack of prenatal care, a frequent occurrence among the uninsured, results in high-risk births and often very high neonatal intensive care costs. In addition, of those who are insured, a significant minority--especially those with individual rather than group coverage--still run a significant risk of incurring medical bills they cannot pay, and therefore are "underinsured" for catastrophic care. One study found that about one fourth of the non-elderly population--more than 57 million people in 1985--is either uninsured or underinsured. Although much of the discussion regarding catastrophic health insurance has focused on the elderly population, children and their families also suffer from the effects of catastrophic illness. Although Medicaid covers poor children, benefits vary widely from state to state. It is estimated that 12 million children under the age of 18 are uninsured. And even for families with insurance, a traumatic childhood illness or a serious chronic disease or disorder could result in financial catastrophe for the family, either through increased out-of-pocket expenses or wages lost because of time spent with an ill child.

In a sense, uncompensated care costs represent a second stage of catastrophic care costs, after a person or family can no longer pay out-of-pocket for uncovered care. In 1985, uncompensated care (charity care and bad debt) provided by hospitals to those unable to pay cost hospitals--and, indirectly, other hospital patients--\$7.4 billion. This was over double the cost in 1980. Given the current conscientious debt-collection efforts made by hospitals, this \$7.4 billion represents costs that patients could not pay, i.e., clearly catastrophic costs.

In short, while discussions of the catastrophic care problem frequently focus on the dramatic, relatively rare, acute care expenses of the elderly, the catastrophic care problem is much broader and much deeper, extending to both young and old, uninsured and insured.

COMMENTS ON THE MEDICARE CATASTROPHIC PROTECTION ACTS OF 1987

H.R.1280 and H.R.1281 would:

- o Eliminate the day limitations on acute inpatient hospital care except for inpatient psychiatric hospital care;
- o Eliminate the confusing spell-of-illness concept and impose only one first-day hospital deductible a year;
- o Eliminate all copayments for inpatient hospital care;
- o Expand skilled nursing facility (SNF) benefits from 100 to 150 days and impose revised, lower SNF copayments of 20 percent of average SNF costs for only the first seven days of SNF care each year;
- o Eliminate the 210-day limit on hospice care;
- o Limit Part B copayments for covered services to \$1,000 per year; and
- o Fund these expanded benefits by taxing Medicare beneficiaries on a portion of the actuarial value of Medicare benefits.

These proposed changes in the Medicare acute care benefit are a first step in addressing the problem of catastrophic expenses for Medicare beneficiaries. Although there is only a small expansion of coverage, H.R.1280 and H.R.1281 would provide several important things:

- o Relief to those beneficiaries who experience significant copayment and deductible expenses for covered services, particularly those with low to middle incomes;
- o Peace of mind for those beneficiaries frightened by the possibility of significant cost sharing for covered services; and

- o Simplification of the benefit and cost sharing provisions so that beneficiaries would be better able to assess the value of private Medicare supplemental insurance policies.

There are some expansions and alternative approaches that we would urge be considered in refining H.R.1280 and H.R.1281. They fall into three categories: (1) additional changes in covered acute care services, (2) methods for financing catastrophic coverage, and (3) technical issues.

Covered Services

The AHA supports elimination of acute inpatient hospital day limits and restructuring of copayments and deductibles to make the benefit package less complex and more understandable. Although the configuration adopted in H.R.1280 and H.R.1281 differs from that which we recommended last year, it is generally consistent with our goals of simplifying Medicare and reducing barriers to care for beneficiaries. These changes also will have a positive effect on out-of-pocket beneficiary expenditures.

We recommend several expansions of the acute care benefit to reflect changing patterns of health care delivery.

Expanding Access to Non-inpatient Acute Care. The original Medicare benefit was structured around the belief that most acute care occurred in inpatient hospital settings. This is no longer entirely true. Services that are not covered at all by Medicare, such as prescription drugs provided to non-inpatients, have become an increasingly important part of medical expenditures of the elderly. The principal barrier to coverage has been the fear of substantial utilization and cost increases resulting from coverage for beneficiaries who use small amounts of services or for whom the costs of such services are a small percentage of income. These problems can be reduced by expanding the set of covered services to include prescription pharmaceuticals, but limiting that coverage with an annual deductible and copayments until an annual out-of-pocket limit is reached.

The most significant problem results from major changes in delivery patterns and the increased reliance on alternatives to inpatient hospital care. Expenditures for outpatient services have risen as care has moved from the inpatient setting to the outpatient setting—for example, in the substitution of outpatient for inpatient surgery. Out-of-pocket expenditures for beneficiaries have been increasing as a result because outpatient services more often carry copayment requirements. H.R.1281 would address this problem by placing a \$1,000 cap on premiums, copayments, and deductibles for Part B covered services.

A second source of increased out-of-pocket expenditures has been for covered SNF care. H.R.1280 would expand coverage of skilled nursing facility services by changing the copayment computation and extending the day limit from 100 to 150 days. The proposed modification of the copayment is very positive—the 20 percent of average daily SNF cost (about \$24 initially) for seven days is a significant improvement over the current \$65 a day for days 21 through 100. The current copayment level virtually eliminates the SNF benefit for all but the first 20 days.

A third source of increased out-of-pocket expenditures is skilled nursing and home health services for which Medicare coverage is denied. Medicare beneficiaries are often caught up in the patent absurdity of being told they are not sick enough to warrant admission to a hospital, but they are too sick to be treated at home, and they cannot be treated in a skilled nursing facility because they have not met the three-day prior hospitalization rule. Medicare administrators have used the absence of clearly defined coverage criteria to apply increasingly stringent medical criteria to skilled nursing and home health claims, resulting not only in the denial of coverage but also increasing reluctance on the part of some providers to accept Medicare patients.

The most pressing need is to require that medical review criteria used by fiscal intermediaries be written and made available to providers and beneficiaries to promote understanding of the benefit and better assessments of the appropriateness of claims denials for home care and skilled nursing care.

Making some sense of coverage criteria for these services also should focus on a sorting out of where beneficiaries should be cared for when they have an acute episode of illness, and on providing the flexibility to use the appropriate level service without artificial barriers. In the course of doing so, it will be important to establish more appropriate conditions under which the services will be covered, including relaxation of the "home-bound" and "intermittent care" requirements for covered home health care, and elimination, in whole or in part, of the three-day prior hospitalization requirement for receipt of SNF care. These additional changes to the benefit would substantially improve beneficiary access to non-hospital services for acute episodes of illness.

Though the need for post-acute non-hospital care has been increasing, the availability of skilled beds for subacute placement has been shrinking. Several states have restricted nursing home bed growth; for example, six states have imposed moratoria on the addition of new nursing home beds. Medicare needs to eliminate arbitrary barriers to the provision of needed skilled subacute services by qualified hospitals. Where extended care services are needed but appropriate placement is unavailable, hospitals should be able to provide the services and be paid for them at the commensurate level.

In reevaluating the home health benefit, it is worth distinguishing between uses of the benefit as an adjunct to an acute episode of care, and use of home health services for long-term care. Congress may be wary of changing the benefit for fear of expanding coverage without controls related to the elderly's long-term care needs, which to this point Medicare is not designed to address. But there are positive changes that could be made that would enhance its use for post-acute extended care in a way that does not expose the program to unlimited liability. The AHA and other organizations are looking at this issue with an eye to improving the way the benefit functions and we would be pleased to work with this subcommittee in suggesting further changes.

Eliminating the Limit on Acute Inpatient Psychiatric Care. H.R.1280 would eliminate all limits on coverage of acute inpatient hospital care with the exception of the 190-day lifetime limit on acute inpatient psychiatric hospital care.

It is time to reconsider and eliminate the 190-day limit as outmoded and unnecessary. With extensive utilization controls and cost-per-case limits on payment, there is no basis for perpetuating a two-class system of coverage for psychiatric and non-psychiatric illness. It is inappropriate to substitute a limitation on benefits for effective utilization review, particularly given the active involvement of the psychiatric community in substantially improving utilization controls since Medicare was enacted.

In the past decade, there have been significant advances in psychopharmacology and biological testing that have resulted in more precise diagnoses and efficient approaches to treatment. There is also widespread and persistent evidence of the reduced rate of increase of medical expense following mental health treatment which argues for the inseparability of mind and body in health care. All public and private health insurance programs for financing health care should include benefits for the active treatment of mental illness and substance abuse and dependence that are equal to benefits provided for physical illness and disability.

Method of Financing

H.R.1280 and H.R.1281 use taxation of a portion of Medicare benefit actuarial values to generate revenues that would be passed back to the Medicare Hospital Insurance trust fund. The advantage of the taxation approach is its sensitivity to the income of individual beneficiaries. It is an important advantage for the 49 percent of the elderly whose annual incomes are less than \$10,000. The primary disadvantage of the taxation approach is that it creates an arbitrary premium because the premium is a function of the current average value of Medicare benefits, current tax law, and the current income distribution of the Medicare population, rather than the cost of the expanded benefits. A more straight-forward approach is the use of an actuarially sound premium to cover the cost of additional coverage. This approach explicitly relates financing to the cost of the beneficiary benefits. The primary disadvantage of a premium approach, of course, is it has no income sensitivity.

Although more complex, the idea of combining a universal premium with protections for low-income beneficiaries merits some examination. For example, Medicaid coverage could be restructured as an SSI supplemental package to cover copayments and pay the Medicare premium for those beneficiaries for whom even limited out-of-pocket payments would be a significant burden. For the low-income beneficiary who cannot afford supplemental insurance and who does not qualify for Medicaid coverage, out-of-pocket limits tied to income would be a major positive step.

Technical Issues

There are two technical issues that we believe are significant and require attention.

Adjustment of Hospital Payment Rates. Section 2(g)(5) of H.R.1280 would require that the Secretary take into consideration, to the extent appropriate, reductions in payments to hospitals by Medicare beneficiaries resulting from the elimination of day limits on inpatient hospital services, when computing:

- o DRG payment rates under the prospective payment system (PPS);
- o Target amounts under TEFRA cost-per-case limits;
- o Outlier cutoff points for DRG payment determinations under PPS; and
- o DRG weighting factors under PPS.

The AHA appreciates the attempt to ensure that the proposed coverage changes not yield unintended reductions in payments to hospitals. But, we believe that the intent of this new authority should be more clearly stated and the Secretary should be explicitly precluded from using the budget neutrality requirement as a basis for making adjustments that would unfairly reduce hospital payment. Current experience suggests that elimination of the day limits will affect few inpatient admissions. In 1984, only an estimated 40,000 people had acute general hospital stays longer than 60 days and only 10 people had stays longer than 150 days. Nonetheless, we believe this new authority to adjust PPS and cost-per-case payment should be more tightly drawn.

Hospice Benefit Change. H.R.1280 would eliminate the 210-day limit on the Medicare hospice benefit. We believe this beneficial change could potentially prevent the delayed entrance of terminally ill patients into hospice programs. We understand that current experience shows very short average lengths of stay for hospice patients (30-40 days), with very few patients reaching the 210-day limit. However, many hospice providers believe that the 210-day limit significantly affects physician decisions on when to refer their terminally ill patients to hospice programs, and some hospice programs are afraid to accept potential long-stay patients.

If more patients enter hospice care earlier and reach or exceed the six-month mark, there may be a need to reexamine application of the aggregate hospice per-capita limit on payment. That cap was originally based on an approximate six-month cost of traditional medical care to ensure that the cost of hospice care not exceed the cost of traditional medical care for a comparable period of time. While few, if any, hospices are affected by the cap now, any significant increase in the average hospice stay or in the prevalence of long-stay patients could yield increases in cost without commensurate increases in hospice payment.

CONCLUSION

It is understood that this legislation and the AHA's recommendations above do not address the most common cause of catastrophic medical expenses among the aged: extended long-term care for chronic illnesses, including those involving psychiatric diagnoses and requiring rehabilitation treatment. Medicare pays only for skilled nursing care associated with acute care episodes. Medicaid accounts for just under half of all long-term care expenditures, while individuals pay out-of-pocket for the majority of long-term care. What is needed are more effective ways of using available resources that avoid the tragic and often counterproductive effects of forcing families to impoverish themselves to pay for the care needed by an individual suffering from a chronic illness.

Also, concern over the problem of catastrophic illness among the Medicare population should not draw attention away from the significant problem of medical indigence in the non-Medicare population. Among the population not covered by Medicare--the non-elderly and non-disabled--the major cause of catastrophic expense is acute medical care. Approximately 37 million Americans are without health insurance of any kind, and about 20 million are insured but not for catastrophic illness. When serious illness strikes these individuals, they become part of the medically indigent.

H.R.1280 and H.R.1281 would make a significant contribution toward addressing catastrophic illness, but there are many more steps to be taken. No one should be led to believe that the bills provide a comprehensive solution to the problem. We pledge our support and cooperation in tackling this problem, and urge that you continue with the next steps necessary to address the bulk of the need for catastrophic coverage protection--the 37 million uninsured and 20 million underinsured Americans, most of whom are poor or near-poor, and the growing number of elderly, disabled, and other Americans, who are being crushed by uncovered long-term care costs for chronic illnesses and disabilities.

Chairman STARK. Thank you very much.

Dr. Schenken, in your testimony you indicate some support for State risk pools for uninsured, underinsured and uninsurable. Now, last year Mr. Gradison and I had legislation to encourage States—really to require them, but we said encourage—to take care of uninsurables, which to me are people with diseases like diabetes where nobody will give them insurance—a very small number of people. I think 7 or 11 States already have it.

Would you or the AMA support this kind of mandatory requirement that the State establish these risk pools?

Dr. SCHENKEN. Yes.

Chairman STARK. My other question. You testified that catastrophic coverage could be provided more efficiently and effectively by the private sector. Now, a couple of comments, and then I would like you to expand on it a little bit.

It is my understanding the private sector has had 22 years to fill in these gaps and they have not done it.

And second, none of them offer open season. Almost all of them exclude preexisting conditions, which they probably cannot. I am not criticizing. They are paying back only 60 cents on every premium dollar, whereas the Government, obviously because the taxpayers are picking up a lot of the overhead, and it is mandatory, can provide 98 or 96 percent, whatever you want to say, and include all preexisting conditions.

Now, why would you make an assertion that they can do it better in the private sector?

Dr. SCHENKEN. Well, Mr. Chairman, the Medicare program has been evolving over 20 years. And there have been serious restrictions placed upon the private insurance companies in the way that they could sell these policies and the way that they could integrate their policies.

Chairman STARK. Such as.

Dr. SCHENKEN. They do not have the ability, for instance, to integrate for a total policy. There has been no voucher program, for an example, where an insurer would offer the full Medicare package with additional benefits. I am not here as an expert in the insurance company.

Chairman STARK. Yes, all right.

Dr. SCHENKEN. But we believe that given the new approach toward looking at the bigger picture with the addition of vouchers and all of the other things which we have in our program—

Chairman STARK. Now, wait a minute. Are you suggesting a system where every Medicare beneficiary would get a voucher?

Dr. SCHENKEN. Vouchers are part of our plan.

Chairman STARK. But what you are suggesting is a voucher to replace the existing Medicare coverage.

Dr. SCHENKEN. Some of it, yes.

Chairman STARK. Well, I am afraid that begs the question a little bit. It is only a question of the size of voucher. I agree there. If you give everybody \$1,000 a year extra in a voucher, they will go out and buy something better with it. That is no problem.

But is there any evidence that cost—let's just say with the costs locked in, as we are trying to do, how does that—

Dr. SCHENKEN. Mr. Chairman, it is our belief based on the preliminary studies we have done that given expanded horizons, the private sector can do it. And what we are really requesting is to be able to work with you and with other people to see as to whether it will work.

Chairman STARK. Well, give me an example. I would love for you to share with us your preliminary findings. But we have had no testimony from the private sector that they can do it.

Dr. SCHENKEN. Well, the Department of HHS apparently feels as if this is worth exploring because of their encouragement to the competitive medical plan, HMO, PPO, that approach. Another example is the Federal Employees Health Benefit Plan (FEHBP) where Federal employees and retirees choose from a vast array of private sector plans.

Chairman STARK. Not exclusively. I suspect that the AMA is aware that they are going to allow a fee for service to continue—within a year or two anyway.

Dr. SCHENKEN. We are not looking—yes, at least. We are not looking for an exclusive program either, sir.

Chairman STARK. No, they are not either. I am not suggesting that. I am just saying that in all seriousness, just in a very empirical sense, philosophy notwithstanding, it is tough for me to see how you can expect the private sector to compete. They do a good job in a lot of areas. But unless they have got 100 percent, as the Government would have, or 98 percent of the people enrolling, how do they spread the risk enough?

Dr. SCHENKEN. They have done very well in the patients under 65, and we believe they can do it over 65.

Chairman STARK. But with a very limited group. They have exempted or eliminated preexisting conditions. If you go in with a hangnail, they will not insure anything from the elbow down for the next 50 years of your life. These guys write preexisting conditions at the drop of a suture.

Dr. SCHENKEN. Well, Mr. Chairman, if preexisting conditions are a fiscal problem, they will be an equal fiscal problem for the Government or for the private sector.

Chairman STARK. No, because we do not have any selection. You see, if we get everybody, we get the healthy with the sick. And what the insurance companies are stuck with in a voluntary plan is obvious. If you pick one insurance company and let them run the program, they could do it as well as HCFA, I am sure, but that is not what we are doing.

Dr. SCHENKEN. If you permit adverse selection, you are at that risk. We are hopeful that in our approach we would be able to minimize it. However, there is no evidence that for all certainty that any of the HMO plans have yet been able to exclude or include adverse selection.

Chairman STARK. Let me ask you this. We are pretty sure that we know the complete costs of our plan—Dr. Bowen, Mr. Gradison and myself—just relative to part A and B and this very limited expansion of benefits, which basically would, for the physician's part—which I am sure you are somewhat more interested in than part A—after the first \$1,000 of co-pay, Medicare will pick up everything else. Now, there may not be a whole lot more. I suppose a

major heart operation is \$4,000 or \$5,000, so somebody still might be out-of-pocket. That might just eat up the \$1,000 right there. And heaven knows, that is catastrophic for some people.

But it is simple. If you want to lower it to \$500, I would be the first one to jump in and do that. On the part B side you are still paying 20 percent of the doctor's bill. We will limit that out-of-pocket to some dollar amount, period. And on the part A side, it is even simpler. We are limiting it to \$500. That is the last hospital bill you will pay until you die or until next year.

It does not cost a whole lot. It takes out a lot of confusion. I am sure that you will agree with me that, if we had to give 9 out of 10 Americans a test on Medicare and Medicaid and all the various benefits, they would fail—and I might still if I did not look at this sheet every time.

What is wrong with taking that little extra step to just smooth out the benefits, simplify it? There is still a lot of services or benefits that are not covered. Is there any objection if we can afford that, on the one hand, to expand that benefit in Medicare?

Dr. SCHENKEN. Let me precede it with a small observation. And that is, you asked the question about the insurance had 20 years to do some things—

Chairman STARK. Twenty-two.

Dr. SCHENKEN [continuing]. Twenty-two, and they did not do it.

Well, I think it is important that we not throw stones and look at who is at fault for all these different things. But Medicare has also had 22—

Chairman STARK. I just want to make the point, we gave them the chance for 20 years before the Government got in.

Dr. SCHENKEN. I am expanding the observation. Medicare has had 22 years to do the things that it started out to do. And the AMA in 1965 indicated that the cost would be way higher than it was predicted to be, and of course, we were correct.

Chairman STARK. Yes, but you also supported cigarettes in 1965 to get a bunch of tobacco State people to vote against Medicare. So, let's not get into what AMA did in the past so we get on thin ice.

Dr. SCHENKEN. Well, the political process can be opened in a variety of different ways, Mr. Chairman.

But to get back to the point, we have watched what has happened to Medicare, out-of-pocket expenses, the deductible which went from \$30 or \$40 for the hospital up to \$520. So, we have great concern on expanding the Government's side of this.

All we are saying is that we feel that the private sector has as much chance or a better chance of providing this, and now in times of budget problems and so forth, we are suggesting give them the chance.

Chairman STARK. Would you support mandated Federal standards for medigap insurance?

Dr. SCHENKEN. We have, haven't we?

Mr. RUBIN. We supported the Baucus amendment.

Chairman STARK. No, no. Not the—mandated Federal standards for health insurance.

Mr. RUBIN. I think we would have to look at that more closely. But I do not think that there would be a tremendous objection to that, especially in light of the fact that one of the major insurers

has already indicated that they can offer the Bowen package at no additional premium.

Chairman STARK. Not eliminating preexisting conditions.

Dr. SCHENKEN. Mr. Chairman, let me respond to it in a different way. We are going to—if our plan is adopted, we are going to require standards for the overall plan. So, I would assume then that we would be willing to look at standards for the medigap plan as well.

Chairman STARK. OK, I will give you a little time to rethink that one because as I say, this is an area in which the Federal Government has yet—it is water we have not stuck our toe in yet. And I am not sure that—

Dr. SCHENKEN. Standards, of course.

Chairman STARK. I am not even sure with the political might of me and you, Doctor, we would be able to get that one by the State insurance commissioners. But I mean that. I have a hunch that is a long way off for us in being able to achieve it.

Dr. SCHENKEN. We have the same problem with the ERISA failing to look after some of the benefit plans on the local level.

Chairman STARK. You indicate that you feel our proposal is a means test.

Dr. SCHENKEN. It is beginning the concept of recognizing means testing.

Chairman STARK. Could I see if you and I could sort out some semantic differences there?

Means testing generally by those who are concerned about it has referred to access. And I think this is a key difference. And I would hope that maybe I could convince you that ours is not means testing.

In other words, in welfare connotation, the means test qualifies one for supplemental security income. I think that is where the concept of means testing comes. And people are rightly concerned about that.

Ours—and we use a different word here—is income relating the cost, the premium, or the tax. Six of one, half a dozen of the other to me whether you relate the premium to your income or do it through the Tax Code.

Can you follow with me? The difference is very important. One, Social Security is not means tested, you see. Everybody who is in the program, which is just about everybody in the country, gets a Social Security benefit. We relate the cost and the benefit to your income. But we do not means test your ability to get in.

And by the same token, I think the Stark-Gradison proposal does not actually means test. It does, indeed, relate the cost to your income. And I do not know whether that takes away any of your concerns. But I wonder if you appreciate and would stipulate to that difference with me because there are some groups, in which I would include myself, who do not want to measure your ability to participate in the program by your income.

Dr. SCHENKEN. I recognize the sensitivity of the term, means test, and really would not get into a discussion one way or another. I would simply make the observation that what we are doing is relating the cost one way or another. You said, six of one, half a dozen of the other.

Chairman STARK. To income.

Dr. SCHENKEN. To income.

In our view this reflects the fact that the affluent are going to have to face up to some cost that the Government is now picking up. Ways and Means Committee faced up to that in the past when you began taxation of some Social Security or some benefits if the total income was over a certain level.

There are many who view this as "machts nichts" in terms of a means test. I will not get into the semantics with you, but it is an approach to parity which we—the concept we think is important.

Chairman STARK. Well, you do not object then, I gather, to the approach of taxing Social Security benefits. I mean, that—

Dr. SCHENKEN. That is—

Chairman STARK. If we have to relate it to income. Let's assume politically we have to let the lower income folks out of the box and not pay.

Dr. SCHENKEN. That is not the way we are suggesting it, but we are not opposed to your way either till we look at it.

Mr. RUBIN. Mr. Chairman, if I could also—

Chairman STARK. Sure.

Mr. RUBIN. Back on to the State risk pools. One of the problems we found about State risk pools is not only that not all the States have them, although more and more have. Illinois has just passed one. But that self-insured businesses are not part of the pools because of a preemption in ERISA, that prohibits the States from requiring participation in plans that are—

Chairman STARK. Sure. Our bill I believe takes care of that. We certainly give the self-insured plans the option not to join, but they just lose their tax deduction. We thought that might encourage them to do the right thing and sign up. I hate to call it coercion, but I think that may solve your problem.

Mr. RUBIN. And for the record we support that approach.

Chairman STARK. Good. Thank you. Mr. Daub?

Mr. DAUB. Thank you.

Dr. Schenken, I did not mean to indicate in any way, shape or form that you were not just as esteemed, a good friend of mine as well, and for whom I have looked to counsel for the input into the bill that I will be introducing this week that attempts to look at this whole thing in a broader way.

Dr. Schenken, it is our normal custom and practice to leave all witnesses with the impression that when they are done they have been harassed. And I am going to try my best now to do that by asking you the following question.

Medicare now places no constraints on the volume of physician services. The program is basically open-ended. Can we be assured that elimination of cost sharing above a cap which is recommended, the cap of \$2,000 or whatever, for part B will not encourage a provision of unnecessary services?

Dr. SCHENKEN. Yes, I think so. We feel that a reasonably low cost-sharing is an appropriate way to utilize services, but cost itself should not be the way to restrict services. We have utilization review, peer review and so forth. And, no, we do not feel that reducing cost-sharing after a certain amount had been expended would be a problem.

Mr. DAUB. I appreciated the testimony given by you on behalf of the American Medical Association with respect to the private sector's role. It is very easy to say the Government ought to do it. And we are trying to figure out how to pay now for heart transplants and dialysis and all of those things, including Alzheimer's disease. We know about that disease. There were pictures of it on the caves, but people did not live past age 48 either. So society as a whole did not have that problem to see, to get emotional about and then to try to figure out how to handle it.

Now our life spans are much longer, thanks to medical science and technology and being healthy. Now we endeavor to decide, as our population demographic shifts, how we are going to handle all the medical problems of a very large and rapidly expanding elderly population.

Why should Congress at this point decide? Is it because it is impatient? Is it because it is politically convenient to go home and promise old people that we are now going to take care of some more of their medical bills? We are only talking about acute-care coverage, and your statement says we should basically try to stick to this. What about prescription drugs? What about nursing care, home-assisted care? What about the fact that we are just going to be old at age 90 but we are not going to be sick?

Is that why the AMA is reluctant to endorse the Government programs again?

Dr. SCHENKEN. Again, let me go back to the situation in 1965. I think people have forgotten that the whole health insurance system basically began after World War II and it expanded but it was only marginally expanded by the early 1960s. And we are in a different situation right now. We feel, as many people feel, that the Government has enough problems with its budgets and other things and that the private sector is in fact the best way to start looking at these problems, and they are mammoth.

But we see very good evidence that the multiplicity of plans, the indemnity plans, the PPOs, the IPAs, the HMOs, having those choices available to people with competition being what it is, will provide that answer.

Now the other issues which you have brought up, indigent care and long-term care, are equally important. But we do not believe that we should try to blend them into this solution at this time, because not enough is known about them. We like to take them serially if we can, but they are urgent. Let's do what can be done with the resources available and go on from there.

Mr. DAUB. Mr. Owen, if today the committee were deliberating raising the copayments and the deductibles, and charging part B premium payers 35 percent of program costs instead of 30, or 30 percent instead of 20, do you think we would be getting very far politically here?

Mr. OWEN. Politically?

Mr. DAUB. Yes.

Mr. OWEN. No, I do not, but I think you—

Mr. DAUB. Then why are we going to turn around and charge everybody \$4.92 or \$6 or \$10 or \$12 to pay for this program according to what the President suggests?

Mr. OWEN. Well, my comment would be—

Mr. DAUB. Is it not the same thing? How come all of a sudden is the thinking different? We are going to charge everybody for helping about 200,000 people out of 30 million.

Mr. OWEN. Well, you are only talking about one program right now, which is Medicare and that is the program that you are looking at, and that is the trust funds and the dollars come out of payroll taxes to pay for it and what have you.

But I think that what you charge the Medicare beneficiary and whatever that deductible is, whether it is \$500, \$1,000 or \$2,000, I think you have to look at what makes up the program of the part B sector of it, because it is not all inpatient any more.

I think you get more political credit if you looked at some of the other things that the elderly are most concerned about such as prescription drugs and some of the other things that they are paying for, and included that in the program and then put a deductible or an amount of money at which this catastrophic kicked in after they paid a certain amount.

I think you get more support politically if you did it that way than if you do not change any of the benefits and just start talking about what the deductible is and what is there.

As I said in my statement, the catastrophic portion of this is very small, the inpatient hospital care is very small as far as Medicare is concerned. It does not mean a whole lot to the hospitals, but it does ease the fear in a lot of the elderly's mind that they are going to be bankrupt because of inpatient hospital stay.

Mr. DAUB. Let me ask you this final question. Under current law Medicare pays bad debt for beneficiaries who do not pay their hospital deductible or coinsurance.

Mr. OWEN. That is correct.

Mr. DAUB. How quickly does Medicare generate reimbursement for your bad debt and to what extent will Medicare catastrophic as a proposal improve your cash flow? I think I know the answer.

Mr. OWEN. Well, it may not improve it at all, because right now when a patient runs out of his benefits, you can bill the patient and the patient may be wealthy enough to pay the hospital charges rather than the DRG price which was set by government. So there could be instances where the hospital would actually get less money if the hospital is located in an area that is fairly well to do elderly populations, say in Arizona, Sun City or places like that as an example.

On the other hand, the DRG prospective pricing system is paid not on the basis of days any more, but on diagnosis. And then there is some outliers which are paid for in additional days, and that is about the only thing that this is going to help as far as hospitals are concerned.

Now if the patient does not meet those obligations that they are supposed to, deductibles, then Medicare does pay that bad debt, but it comes to the hospital considerably long time after the patient has been discharged. It is not a cash flow that is going to help the hospital very much, because by the time you find out whether the patient can pay it or not and then the bad debt, it could be 6, 8, months, a year.

Mr. DAUB. Well, I guess I have a philosophical concluding question then to both of you. Would it be a better policy option for us if

we are going to spend \$10 billion to do something more for health care costs for elderly, to put that \$10 billion into acute-care coverage, as is being discussed now most intently, or to put it into nursing home care and other long-term care with the appropriate income-related tests? Which is the right thing? If we are going to do this, and there seems to be a political pension here for us to do something this year, and figure out in some fancy way how to pay for it that is not a tax increase or perceived as too unfair and give everybody some bang for their buck, are we better off making more government out of what we have, or taking this commitment that we are making politically and maybe putting it over on to the longer term health care problem?

Mr. OWEN. Well, if I could just comment to start with. I think you are talking about something that—if you are just talking about Medicare, maybe you are talking about redefining the part A, part B and maybe adding a part C.

Mr. DAUB. Maybe adding a part C.

Mr. OWEN. Who knows. There are a number of different approaches as you well know, Congressman, that can be used in that.

If you are talking about including all of the population in what might be considered catastrophic, then you have got a bigger problem. It is true that the long-term care, most of it is elderly population and eventually we are all going to reach that stage. But it seems to me that it is such a huge problem from the standpoint of dollars that there has to be private funds, Government funds, Federal funds and State funds possibly included. We have got to start something that begins with young people today who are now putting money away that is going to take care of them when they are 80 years old. You cannot start at age 65 and say now you have got to start putting away money which is going to take care of you at age 85 or buy an insurance policy. It is too late, and it seems to me that we ought to be talking about what are the ways in which we bring in the young working person, the 20, 25 and so forth and start to put away funds some time like part of the pension program that he is involved in, and funded.

Mr. DAUB. You will like the legislation that I am going to introduce which gives two incentives to the work age under 65 group to provide for just that opportunity.

Mr. Schenken, did you want to say something?

Dr. SCHENKEN. In the context in which you phrased the question, Congressman, since we feel that the private sector approach really is the best way to go for catastrophic, we feel if there are additional Federal moneys to be used that they would be better put into long-term care, especially in the restrictions now that Medicare has on the interim long-term care that they could beneficially provide.

And I would like if I could, Mr. Chairman, to take this opportunity to raise another issue with you if I could, a short one?

Chairman STARK. Certainly.

Dr. SCHENKEN. Medicare, of necessity, is broad and uniform in its approach. But I would like to at least ask you to give particular concern about the problems of rural American. The Medicare situation in rural hospitals and in rural physicians is a real problem and the catastrophic portion of it is even worse in the depressed economies and so forth, because many of these hospitals are small.

They have 70 percent, 75 percent Medicare patients. It is not the same in rural America as in urban America. And as you deliberate, I would hope that you would be able to take some look at the unique problems of rural America and maybe do something about them as well.

Chairman STARK. Well, Doctor, that is an issue that comes up. I would submit to you that rural America is equally as unique as some of the impoverished inner city areas, and that is basically our problem. There is no average. I mean everybody else is the average that ever comes to testify before us.

But I appreciate your concerns and, they are I might add, well represented both on the subcommittee and the full committee. And our only problem is finding an empirical way to make that distinction and with some accuracy.

If I might, Jack, I have just a couple of questions. The American Hospital Association, I presume, would have no objection to the Federal Government taking over the full cost of part A and paying full cost first day coverage with no copayments whatsoever.

Mr. OWEN. No, that is not quite true, because we have discovered that when there are no copayments and there is no patient responsibility—

Chairman STARK. A modest copayment let us say.

Mr. OWEN. If there is no patient responsibility, then there tends to be—

Chairman STARK. Absent that sort of prohibition against over-usage, would you have any objection to us doing it completely if we could expand the benefits—particularly if we could expand the percentage—the amount of the DRGs.

Mr. OWEN. You mean if the Federal Government had copayments and they just—

Chairman STARK. Let us just suppose for a minute that the Federal Government eliminated any—you have testified that the most that Medigap policies can possibly pay under part A is \$18,000 to \$19,000, round figures.

Mr. OWEN. Right.

Chairman STARK. Let us suppose we just eliminated that and we agree on some minimum entry fee, \$100 or whatever it would be to prevent capricious usage. Would you have any objection to that?

Mr. OWEN. We would prefer to see some element of private enterprise in there, but we have no policy against the government doing it; that is correct.

Chairman STARK. What element of private enterprise would you like to see in there?

Mr. OWEN. Well, the insurance companies—some role at least to keep everybody honest.

Chairman STARK. You mean us.

Mr. OWEN. I said everybody.

Chairman STARK. Doctor, you indicated that you did not like the idea of payments to hold down excessive usage, and you indicated that I guess it is the peer review operation that checks up on that for doctors, is that—

Dr. SCHENKEN. It checks up on looking at appropriateness of care.

Chairman STARK. OK. And you think that is the way to go.

Dr. SCHENKEN. We believe that there is a part to play for both of them, but we do not want excessive deductibles and copayments to be the mechanism for restricting care.

Chairman STARK. OK. Why do you think it is a good idea for this utilization review, that is what it is called, right?

Dr. SCHENKEN. That is one of them, yes.

Chairman STARK. Why would you want to make it more difficult to have due process in those procedures and make it more difficult for them to penalize physicians who abuse that?

Dr. SCHENKEN. I do not think those are related. I think due process is a right of anybody, including physicians. And the operation of the peer review organizations should not be predicated on denying anybody their rights, including physicians.

Chairman STARK. So you do not like the Massachusetts plan.

Dr. SCHENKEN. I am not familiar with the Massachusetts plan.

Chairman STARK. The State just takes their license away when they charge too much.

Dr. SCHENKEN. Then I do not like it. [Laughter.]

Chairman STARK. OK. Well, I thank the panel for their testimony.

Our next panel deals with interest groups. Karen Ignagni, assistant director of the Department of Occupational Safety, Health and Social Security of the AFL-CIO, accompanied by Calvin Johnson, the legislative representative; and Willis Goldbeck, president of the Washington Business Group on Health.

And I would submit, in the interest of saving us a little time, as we have those two, and we might ask Mr. Peter Ferrara, the policy analyst from the Heritage Foundation, the Cato Institute, to join us at the witness table and I would also suggest to all the witnesses that their complete testimony will be included in the record, and urge you to expand on your testimony or summarize it, or dramatize it in any manner that you are comfortable.

And Ms. Ignagni, am I pronouncing that right?

Ms. IGNAGNI. Ignagni.

Chairman STARK. Ignagni. Proceed please.

STATEMENT OF KAREN IGNAGNI, ASSISTANT DIRECTOR, DEPARTMENT OF OCCUPATIONAL SAFETY, HEALTH AND SOCIAL SECURITY, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

Ms. IGNAGNI. Thank you, Mr. Chairman. We are pleased to be here today to testify in support of your legislation. We view it as a major step forward with respect to Medicare benefits, and we view it as addressing a serious unmet need.

Although we fully support the goal of your legislation and most of the major points in the bill, we do have some reservations with respect to financing and would like to offer an alternative for the committee's consideration.

First some general comments.

As you know the risk of catastrophic expenses confronts Americans in three ways, and you have spent a lot of time personally and this committee has in looking at the major crisis with respect to access.

The first would be for individuals who have no health insurance coverage whatsoever, or whom a trip to the doctor or several diagnostic tests would be quite a catastrophe financially.

The second is the problem of Medicare beneficiaries which we are here to deal with today.

And third is the issue with respect to chronic care and long-term care, for which there is very little protection available with the exception of the Medicare program.

We are pleased that you have chosen to begin to address this deep-rooted problem by improving coverage under Medicare. We support the initiative, but we also urge you and the committee to address the needs of the uninsured and explore alternatives for addressing the problem of long-term care.

I might say that AFL-CIO has developed a proposal with respect to providing access to care for those who are in the work force without insurance, and we would be pleased to present it to the committee at an appropriate time.

We are pleased to support your catastrophic initiative because we long questioned the equity of penalizing most seriously ill people by requiring out-of-pocket payments for long hospital stays, extensive physician treatment and by terminating benefits for catastrophically ill patients who need inpatient care.

We see this as an important first step, but we strongly urge the committee not to limit its action to acute care. We do hope that you will take into consideration the needs for those who are without coverage for prescription drugs, especially for maintenance drugs, and for some very basic preventive health care services.

We believe, Mr. Chairman, by doing away with existing copayments for hospital care and limitations for covered days your legislation will make the Medicare benefit package more relevant to today's medical practice patterns.

We support your proposal to limit the out-of-pocket burden on Medicare beneficiaries to a single annual deductible indexed to the Social Security cost of living.

We support eliminating the existing but totally arbitrary cutoff of payment for hospice care, and decoupling the in-patient deductible and the co-payment required for skilled nursing home care, and obviously capping the out-of-pocket obligation for part B services.

Although we applaud your efforts to develop a progressive financing mechanism to raise revenues to defray the cost of these benefits, the AFL-CIO has some fundamental concerns about taxing a proportion of the actuarial value of Medicare benefits.

Unlike Social Security where individuals receive cash payments, Medicare provides entitlement to benefits. Depending on their health status, beneficiaries may or may not incur health care costs. In our view, taxing the value of Medicare benefits would be a precedent for taxing fringe benefits provided to individuals in the work force.

We recently fought and won a tough battle to preserve the tax-free status of health care benefits provided to employees and would strongly oppose introducing that concept into the Medicare program.

However, we do want to propose an alternative for the committee's consideration.

We note that Congress has already provided an earned income tax credit to low-income single parents. This is a valuable precedent for our suggestion. Like the earned income credit, we would propose that a credit be provided to low-income seniors to assist them in financing the cost of the proposed new Medicare benefits. Such a credit should come off the bottom of the tax return and not involve any type of up front deduction.

To design the most progressive system, we would suggest that Congress provide a full credit to households with incomes under 100 percent of the poverty line and gradually phase out this relief as adjusted gross increases, so that over a certain income level, say 150 percent of poverty, the credit would be phased out.

Mr. Chairman, we are prepared to work with you and your colleagues to develop this and other alternative financing mechanisms.

I would like to conclude my testimony by making one point about the private sector being allowed to offer Medicare catastrophic benefits.

We agree with you and the statements you have made thus far that the private sector has had 22 years to offer a decent catastrophic benefit package to seniors. They have not done so. And so we are pleased to join in support of your legislation requiring the Medicare benefit package be expanded in this particular area.

Thank you.

[Statement of Ms. Ignagni follows:]

TESTIMONY BY KAREN IGNAGNI, ASSISTANT DIRECTOR
DEPARTMENT OF OCCUPATIONAL SAFETY, HEALTH AND SOCIAL SECURITY
BEFORE THE HOUSE WAYS AND MEANS HEALTH SUBCOMMITTEE
ON CATASTROPHIC MEDICAL EXPENSES

March 10, 1987

The AFL-CIO is pleased to have this opportunity to comment on H.R. 1280 and 1281, providing Medicare beneficiaries protection against catastrophic medical expenses. We commend you, Mr. Chairman, and your colleagues for taking the lead in addressing a problem which theoretically affects only a small segment of the elderly population but in reality, because of the financial devastation catastrophic illness can cause, the threat of it is uppermost in the minds of elderly citizens. This is a matter with which the AFL-CIO Executive Council was concerned at its meeting last month. I attach to my testimony the statement on catastrophic health insurance the Council unanimously adopted.

Your initiative takes a major step towards making Medicare benefits more comprehensive and thereby addressing a serious, unmet need. Although the AFL-CIO fully supports this goal and most of the major points in the bills, we have some reservations about the financing mechanism being proposed and would like to suggest another alternative for the Committee's consideration.

First some general comments. As you know, the risk of catastrophic expenses confronts Americans in three ways:

- o Millions of individuals throughout their working lives and/or after they retire and before becoming eligible for Medicare remain without any health protection. For them even a trip to the doctor and several diagnostic tests can be out of reach financially.
- o Medicare beneficiaries may require long hospital stays and repeated physician consultations resulting in out-of-pocket expenses which greatly exceed what Medicare or their private supplemental plans cover.
- o Individuals of all ages, especially senior citizens, who have chronic conditions or are in need of long-term care have, with the exception of those who are or become eligible for Medicaid, little, if any, protection against the financial devastation that a long illness can cause.

Congress and this Committee have chosen to begin to address the deep-rooted problem of access by improving coverage under Medicare. We support your initiative but also urge you to take action to address the needs of the uninsured and begin exploring alternatives for addressing the problem of long-term care. The AFL-CIO has developed a program for improving access to health care services for workers and their families without health care protection which the AFL-CIO adopted at its recent meeting and which also is attached to my statement.

We are encouraged that the issue of protecting Medicare beneficiaries against the prospect of financial ruin associated with a serious illness has come to the forefront of public concern. Medicare itself was modeled after the basic

insurance packages of the early 1960's and was designed to cover only short-stay acute care. Today advances in medicine have led to better control of chronic conditions and longer life spans. Rising health care costs, gaps in covered services and changes in the practice of medicine have resulted in senior citizens now having to pay more out-of-pocket as a percent of income than they did prior to Medicare's enactment. For people with catastrophic illness, the financial burden is even greater. They must pay high co-payments for long hospital stays and a serious illness can completely exhaust their benefits.

For physician services, an elderly couple must pay an annual premium of \$430 each and satisfy a \$75 deductible before becoming eligible to receive benefits that require a 20 percent co-payment. However, there is no upper limit on their financial liability and essential services including preventive care, substance abuse treatment, eyeglasses, hearing aids, prescription drugs and long-term care are not covered by the program.

The AFL-CIO has long questioned the equity of penalizing the most seriously ill people by requiring steep out-of-pocket payments for long hospital stays and extensive physician treatment and by terminating benefits for catastrophically ill patients who need inpatient care. We view providing protection against catastrophic illness as a needed and important first step, but strongly urge the Committee not to limit its action to acute care. We support expanding Medicare to cover all essential services required by beneficiaries, especially preventive care and prescription drugs.

We also urge Congress to begin to examine ways for beneficiaries to obtain protection against the cost of long-term care. Recent studies have shown that once an individual reaches the age of 65 there is a one in five chance that he or she will need nursing home care. Unfortunately, 70 percent of senior citizens mistakenly believe that Medicare covers long-term care. With the median income for families headed by individuals over 65 at approximately \$14,000, senior citizens cannot afford to remain unprotected for long-term care. Nor can they qualify for the patchwork Medicaid system which requires individuals to virtually pauperize themselves before becoming eligible for protection.

The AFL-CIO believes that Congress must take steps to address the long-term care needs of Medicare beneficiaries, especially needed health care, including chronic care, following an acute care episode. We do not believe that eligibility for long-term care should be linked to a hospital stay. Both community-based treatment and home care alternatives to nursing home care should be available when appropriate.

Mr. Chairman, by doing away with existing co-payments for hospital care and limitations for covered days, your legislation will make the Medicare benefit package more relevant to today's medical practice patterns. We support your proposal to limit the out-of-pocket burden on Medicare beneficiaries to a single, annual deductible indexed to the Social Security cost of living adjustment. This will protect beneficiaries from having to absorb any future increase in the deductible which far exceeds their ability to pay.

We support eliminating the existing (but totally arbitrary) cut-off of payment for hospice care after 210 days; de-coupling the inpatient deductible and the co-payment requirement for skilled nursing home care; and capping the out-of-pocket obligation for Part B services at \$1,000.

Although we applaud your efforts to develop a progressive financing mechanism to raise revenues to defray the cost of these benefits, the AFL-CIO has some fundamental concerns about taxing a proportion of the actuarial value of Medicare benefits. Unlike Social Security where individuals receive cash payments, Medicare provides an entitlement to benefits. Depending on their health status, beneficiaries may or may not incur health care costs. In our view, taxing the value of Medicare benefits would be a precedent for taxing fringe benefits provided to individuals in the workforce. We recently fought and won a tough battle to preserve the tax-free status of health care benefits provided to employees and would strongly oppose introducing that concept into the Medicare program.

Instead, we would propose that the Committee consider a premium-based system with a refundable tax credit for low income beneficiaries. Congress has already provided an earned income tax credit to low-income single parents. This is a valuable precedent for our suggestion.

Like the earned income credit, we would propose that a credit be provided to low-income seniors to assist them in financing the cost of the proposed new Medicare benefits. Such a credit should come off the bottom of the tax return and not involve any type of up-front deduction. To design the most progressive system, we would suggest that Congress provide a full credit to households with incomes under 100 percent of the poverty line and gradually phase out this relief as adjusted gross income increases. So that over a certain income level (for example, 150 percent of poverty) the credit would be phased out.

Mr. Chairman, we are prepared to work with you and your staff to develop this financing mechanism to extend long-overdue coverage for catastrophic expenses to Medicare beneficiaries.

For retirees who currently receive catastrophic protection under employer health benefit plans, we would favor adding a provision to the bill that would require employers, through the end of the existing contract, to continue benefits that would in the future be provided by Medicare.

Statement by the AFL-CIO Executive Council

on

Catastrophic Health Care Protection

February 19, 1987
Bal Harbour, FL

More than 20 years after the enactment of Medicare, there is a national consensus that the elderly and disabled need protection against the prospect of financial ruin associated with catastrophic illness.

Rising deductibles and co-insurance, gaps in covered services and changes in the practice of medicine are forcing senior citizens to pay more out-of-pocket as a percent of income than they did prior to Medicare's enactment. For people with catastrophic illness, the out-of-pocket burden is even heavier. Once they experience a serious illness, beneficiaries quickly exhaust Medicare benefits.

Congress is examining proposals to improve Medicare by protecting beneficiaries against catastrophic expenditures for acute care and by providing coverage for other essential services, such as preventive care and prescription drugs. The Reagan Administration is proposing a plan that is limited to catastrophic coverage. The AFL-CIO strongly supports the congressional initiatives. We are concerned, however, that the current congressional review does not include long-term care. Since one in five persons over 65 requires nursing home care, the lack of protection for long-term and chronic care is a major gap in Medicare coverage.

Protection against catastrophic illness and provision of some other services are a needed and an important first step. We will continue to work to expand Medicare to include all necessary health care services, including long-term care provided at home, in community-based treatment centers and in nursing homes.

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Chairman STARK. Thank you very much.
Mr. Goldbeck.

STATEMENT OF WILLIS B. GOLDBECK, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH

Mr. GOLDBECK. Mr. Chairman, it is a pleasure to be before you again. As you know, our organization is one of very large employers. We are here to support adding an acute care catastrophic benefit to Medicare. We are fully cognizant that this benefit in no way would fulfill some of the rhetoric suggesting that it would remove all concern from all elderly Americans. That is an unsupportable collection of political terms that neither these bills nor any others are likely to achieve. It is terribly important that those who are the potential beneficiaries of the creative work that you, Mr. Gradi-son, and the Secretary are doing not be mislead to think that it is something which it is not.

The need is more than apparent. Catastrophic coverage in Medi-care is simply one part of the price of the great success of aging in America. Medicare catastrophic coverage is simply what each of us would want in our own insurance and for that of our parents.

Passage of catastrophic acute care coverage is probably the only way to move the dialog forward to a serious consideration of the long-term care issues.

Private sector insurance products have not resolved the problem. They should not be forbidden, but this additional effort by Govern-ment to listen to the public voice on an important topic should not be construed as anti the private sector, and I say that coming from the private sector.

For most large employers a uniform Federal response on an issue like this is considerably better than 50 State responses. That would certainly be equally true for an increasingly mobile elderly or re-tired population of beneficiaries.

With whatever plan is finally devised, there is a great need for an honest and extensive educational effort pertaining to what is covered and what is not and how it is to be obtained.

Employers do have some concerns, which is one of the reasons why you do not have a single position from business on issues of this nature. There is a concern about whether or not, as costs go up in the future, there will be a reluctance of Congress to continue to have the premium or the tax increase, whichever methodology you choose, attached to the beneficiary because that is politically more difficult to do every day after the day you pass the bill.

There is a natural reaction, it appears, to pass those increases off to employers in the future.

Furthermore, one of the major concerns is that this would end up being part of a pooling system which, as you know, many em-ployers do not support because that becomes a blank check for pro-viders. It is easy to understand why the AMA would suggest that it is better to have State pools that employers would be charged for rather than strictly public sector programs in which budgets are most controlled.

We support a combination of the features of your two proposals. The employers that we work with would prefer the premium ap-

proach rather than the tax financing approach although that is not a unanimous position. There are other financing mechanisms which should also be explored, and we tried to suggest a few of them in the written testimony that you have.

Explicitly, we support your hospice continuation, the removal of the spell of illness, making catastrophic mandatory if the beneficiary takes part B, not inappropriately limiting mental health, using proven cost management technologies so that this program, whether in public or private hands, does not get out of hand: Case management combined with utilization review, based on private sector experience with catastrophic provisions for the same age group is the proven way to balance quality and efficiency.

We believe there should be a connection with Medicaid and that one of the principal publicly articulated objectives of this entire endeavor be to end spousal impoverishment for older Americans.

Congress should remove the limits on prefunding of retiree medical benefits because everyone that can be covered by prefunded is obviously to the financial advantage of the public and private sectors, as well as to the beneficiary.

There should be tax incentives to make long-term care plans accepted by the young. Health insurance for the self-employed obviously should become tax deductible on the same basis as for those who are fully employed by large corporations.

Let me wrap up my remarks by responding to the suggestion that this will produce a windfall for employers. There is no such thing as a windfall for employers when the entire employer/retiree medical benefit is voluntary to begin with.

If catastrophic becomes a Federal program, there is a greatly increased interest among many employers in applying those same dollars towards long-term care benefits. And, many of the plans from companies that are part unionized, will by dint of the negotiated benefits plan that they already have, will pick up the new premium or tax to finance the catastrophic benefit. So, this is clearly not an issue where there is a windfall available to employers resulting from the Federal policy that you are considering.

As you do develop these plans, whichever methodology is used, I think we have to be realistic that one of the driving problems that the whole country is going to face in terms of aging is a very flawed retirement system that is pushing people out of work at a young enough age so that many will be in retirement longer than they were in the work force.

That produces a circumstance which becomes financially untenable for either the public or private sector. At some point, we are going to have to recognize that our traditional tinkering with Medicare policies must be replaced by a far more comprehensive approach to balance true economic and societal goals.

Thank you very much.

[Statement of Mr. Goldbeck follows:]

PROTECTION FROM FINANCIAL CATASTROPHE

Testimony Presented

by:

Washington Business Group on Health

On behalf of our members, it is a pleasure to have this opportunity to address the many complex issues residing under the umbrella of "catastrophic".

We have entitled this testimony "Protection From Financial Catastrophe" to call attention to a very important point. The issue under consideration is neither a health nor medical catastrophe, rather it is a financial catastrophe.

In our testimony we will provide comments and suggestions about:

- A. How the proposals would effect major employers
- B. What benefits should be included
- C. How catastrophic should relate to other health programs
- D. Financing recommendations
- E. Alternative approaches to consider

Before addressing these topics it is important for us to recognize that you will undoubtedly receive varied perspectives from the business community. While that may not make your job easier, it is an accurate reflection of the diversity of interests and current health insurance coverage provided by different segments of the business community.

In our testimony, we are reflecting the views of the very largest employers. In preparation for this presentation, we have reviewed their benefits and find, as you would expect, that they all provide very extensive catastrophic protection for their employees. Most extend that coverage under very favorable financial conditions to the dependents of those employees. And, 95 percent also provide extensive medical benefits for their retirees.

Because of their product-related interest in the outcome of this legislation, it would be more reasonable to seek the perspective of those insurance companies which are WBGH members through their trade association, HIAA. These companies have been very helpful in our effort to analyze the issues but, on this subject, their product interest clearly exceeds their interest as employers so I would not wish to falsely represent them as having endorsed our statements.

For more than ten years, WBGH has endorsed the concept of expanding Medicare to include protection from financial catastrophe. That is, after all, one of the two reasons Medicare was established in the first place: the other being to increase access to basic medical care services.

As a private sector employers organization, we had three basic questions to address as we considered whether or not to reaffirm this support for Medicare catastrophic in light of the current proposals.

A. Are the catastrophic needs of the elderly adequately served by the private sector?

The answer is a simple NO. This does not mean that millions are not significantly assisted by medigap policies. Nor does it mean that such policies should be forbidden. Despite their considerable contribution, however, medigap policies fail to meet the need for several reasons:

1. They frequently contain pre-existing condition clauses which are the antithesis of a catastrophic protection system.
2. They are too expensive for many of the elderly to purchase.
3. The elderly are often confused and purchase multiple policies with virtually duplicate coverage.
4. According to the new GAO study, many medigap plans fail to meet even the most minimal standards of PL96-265 for returns to policyholder and loss ratios. While the

Medicare plan can operate with a guarantee of more than 95 percent of each premium dollar being returned in benefits, medigap policies are still sold which return 60 percent or less. There is no reason that such policies should be disallowed, but it is clear that the private sector cannot claim to have developed an efficient, economical system that meets the needs of all the elderly...even for protection from the catastrophic costs of acute care only.

5. The key to a successful catastrophic plan is certainty. The value of their insurance is received not only by those who must file a claim but also by all the millions of others who can stop their fear of the economic consequences of a major acute care episode. The medigap policies, subject as they are to the normal fluctuations of business considerations will never be able to remain financially profitable and be able to equal the government's guarantee of protection.

B. If we support a federal catastrophic plan that is limited to acute care, will it help or hinder progress towards the availability of protection for catastrophic long term care costs?

We have concluded that it will help for three reasons:

1. Individuals, knowing that they are now safe from economic catastrophe due to acute care, can turn their own asset accumulation plans to the more nebulous and personal long term care concerns.
2. The insurance industry will find an increasing market for its new long term care and case management products.
3. Employers can apply any savings they will achieve from reduced Medicare supplemental catastrophic coverage to the provision of long term care services for their retirees, or to the prefunding of retiree medical benefits. The latter is especially important in light of the vast liability that currently is undefined. It is our contention, based upon the known liability of many of our members, that the Department of Labor estimate of \$98 billion is significantly low.

C. Why should employers be concerned about this legislation in the first place?

Employers have every reason to be skeptical about the long term financial intentions of government. For the past six years, WBGH members have had their costs increased in the guise of producing savings for government:

1. Medicare became secondary payer for:
 - a. first, workers 65-69
 - b. then, any worker over 65 regardless of age, and spouse
 - c. disabled workers and disabled dependents, under 65
2. COBRA benefit extensions for populations not part of the workforce:
 - a. widows
 - b. divorcees and separated spouses
 - c. terminated workers
 - d. dependent children
3. ~~Proposals~~ to shift costs have not all become law but the goal of assigning new costs to employers was certainly clear in the following proposals:
 - a. mandated risk and indigent care pools
 - b. mandated benefits
 - c. taxation of or cap on the deductibility of health insurance benefits
4. State governments have, over the past decade, added some 600 benefit mandates to employer health insurance.

These changes and the traditional governmental underestimation of future health program costs cause many employers to be skeptical

of the catastrophic proposals. It is this long term fear that, as soon as the rate begins to mount for catastrophic, Congress, unwilling to add more costs to beneficiaries, will once again shift costs to employers.

Despite all these concerns, there are good reasons why many major employers have agreed that WBGH should support 1987 legislation to give Medicare a catastrophic component.

1. When the acute care needed by the elderly is not paid for by Medicare or the elderly, those costs do not go away. They are shifted to the hospital and medical bills of the insured and become an unaccountable cost of doing business. Employers see the catastrophic benefit as a better, more accountable method of paying those costs.
2. We believe that Medicare can use the economic clout of its purchasing power to require cost management standards and to reward quality providers. This will help control government outlays, beneficiaries premiums, and provider bad debt.
3. One alternative to Medicare catastrophic coverage is a growth of diverse state catastrophic care mandates. For national employers, we find a uniform federal approach to be more efficient, cost effective, and comprehensible to an increasingly mobile retiree population.
4. By removing the acute care catastrophic problem, government and the private sector can concentrate its creative and financial resources on the long term care problem.
5. The fact that retirees of some large firms and the wealthier Medicare beneficiaries do not need a government catastrophic plan should not be excuse to avoid helping other beneficiaries who are in need.
6. Major employers are increasingly aware of the indigent care problems and recognize the need to close gaps in access by the most appropriate methods.

We are certainly aware that neither the Bowen nor Stark-Gradison proposals offer comprehensive protection against all financial catastrophe. However, they both deserve praise for taking on important first step.

A. HOW THE PROPOSALS WOULD EFFECT MAJOR EMPLOYERS

As indicated, nearly all WBGH members provide medical benefits that supplement Medicare for their retirees. For some of these employers, the proposals would result in direct savings because a portion of the supplemental coverage they provided would now be part of Medicare and financed by either beneficiary premium (Bowen) or taxation (Stark-Gradison).

For many employers, the cost impact would be neutral because they would: (1) pay the new premium or tax or (2) sink any savings into added benefits, and/or prefunding.

The important thing to realize is that no employer can possibly experience an economic "windfall," as some critics have suggested. Today, 100 percent of employer provided retiree medical benefits are voluntary. No employer is required to provide any catastrophic coverage for any retiree or older worker. Further, the record of employers who do provide retiree medical benefits has, despite the public attention to the few exceptions, been a history of benefit expansion.

Under no circumstances would we support any catastrophic plan which denied those employers who now voluntarily provide retiree

medical benefits the full flexibility to use any potential savings as they wish. This matter should be left totally to the discretion of the employer, the retirees, and where applicable, the collective bargaining process.

B. WHAT BENEFITS SHOULD BE INCLUDED?

We believe there are elements of the Bowen and Stark-Gradison proposals that can be combined and several additional benefit features that should be considered.

Therefore, in addition to the basic catastrophic for acute care protection, we support:

1. Extending the hospice benefit as long as the "beneficiary is still terminally ill". If hospice makes sense -- and it has been proven to do so from both health and economic perspectives -- during the early days of a terminal illness, then it certainly makes sense during the last days, no matter how many days later that may be.
2. Removal of the "spell of illness" condition to help simplify the system and reduce the problem of people caught in transition from one care setting to another.
3. Encouraging case management as the standard for catastrophic acute cases and their subsequent transition to necessary out-of-hospital care.
4. Making the catastrophic benefit mandatory if a Medicare beneficiary elects to take Part B. Unless this is done, we run the risk of the extra premium for catastrophic making Part B less attractive and thus increasingly selected only by those who predict they will be major utilizers...an adverse selection issue of major proportions that will further drive up Part B costs and cause employers to be reluctant to continue to pay the Part B premium for their retirees.
5. Although not a benefit per se, we believe the Social HMO experiment should be expanded as a responsible vehicle for testing new integrated configurations of catastrophic acute and long term care benefits.
6. Many employers already provide a prescription drug benefit for their retirees. This is certainly one of the most popular benefits and one which would greatly reduce the beneficiary's fear of financial drain. However, if such a benefit were to be added, we urge you to apply proven cost management techniques:
 - a. appropriate use of generics
 - b. mail order bulk purchases
 - c. periodic billing (versus separate claims billing)
 - d. limitation to specific drugs for which quantities are needed over protracted periods
 - e. separate deductible and/or co-payment to ensure protection for those who have more expensive prescription drug needs
7. Catastrophic coverage might also include mental health benefits which reflect our knowledge of the vast problem of depression in the elderly.

C. HOW CATASTROPHIC SHOULD RELATE TO OTHER PROGRAMS

There are three issues we would call to your attention:

1. HMO-CMP & Private Health Plan Option
2. Medicaid
3. Cost Management

1. HMO-CMP & PHPO

We have and continue to support efforts by Congress and the Administration to expand Medicare's capitated system options

as soon as possible. The problems with some HMOs should not be allowed to stand in the way of this objective. The presence of a catastrophic acute care provision should help these alternative delivery mechanisms become even more competitive and increase their ability to offer long term care benefits.

The Private Health Plan Option (PHPO) concept, as a demonstration program, is one we support. Several of our members are seriously considering participation and we will be working with the Department of Health and Human Services to assist Secretary Bowen with obtaining employer participation in the design as well as conduct of the demonstration. The catastrophic provision can advance the PHPO concept by reducing the uncertainty of the employer's risk and expanding the number of employers -- and unions -- which may be willing to try this option.

2. Medicaid

There are many ways Medicaid must interface with the catastrophic element of Medicare. None are more important than resolving the growing problem known as spousal impoverishment. The situation today in which elderly families must decide between a divorce or poverty in order for one desperately ill spouse to get care is an unparalleled affront to the values of this society. The catastrophic provisions of Medicare must be designed to connect with Medicaid so this problem is not reduced, it is ended. To do so will probably require some federally mandated increase in the poverty level states are allowed to use for Medicaid eligibility, at least for the elderly poor.

3. Cost Management

WBGH members have provided catastrophic coverage for workers, dependents, and retirees. They have learned that a comprehensive cost management strategy is essential. Medicare will need to significantly increase support for the utilization review and quality assurance responsibilities of the PROs. The mandatory second opinion program will have to be expanded. Discharge planning will take on a whole new dimension. And a major effort will have to be made to keep patients, families, and providers from using inappropriate acute care settings just because reimbursement is available when the level of care actually required is non-acute. Many of these goals have been achieved in the private sector with the implementation of case management.

D. FINANCING RECOMMENDATIONS

Of the two proposed financing mechanisms, our members prefer the premium (Bowen) option. This is a philosophical rather than economic position. We have not found any member who feels the Bowen estimates are high enough. However, there remains a strong objection to the concept of taxing a portion of the value of Medicare.

We also favor several additional financing proposals:

1. Raise tobacco product taxes and dedicate all those revenues to Medicare and Medicaid.
2. Make the cost of health insurance for those who are self employed or in sole proprietorship fully tax deductible and provide incentives for small business to aggregate for the purpose of purchasing more comprehensive and cost effective insurance.
3. Experiment with a medical IRA.
4. Remove the DEFRA limits on prefunding of retiree medical benefits and exempt from federal or state tax the interest earned on those funds as long as that interest is reallocated to the fund.

There are proposals for features of and funding mechanisms that have been suggested for catastrophic plans that we cannot support.

1. Funding through a hospital or other tax on care received. Not only does this represent a user tax rather than an insurance mechanism, thus creating an economic burden on the people who can least afford it, but such a tax also penalizes the very employers and unions which already provide the most comprehensive catastrophic insurance. All this would amount to is one more step by government to undermine private sector cost management efforts. An even worse feature of this concept is that it gives providers a blank check with no direct accountability to those being taxed.

We have the same opposition to any insurance pools which seek to fund their losses at the expense of only those who do provide insurance.

2. Any plan which requires participation by private employers which does not require equal participation by all government employees. To this end, state and local government employees should be immediately included in Medicare and, through payroll taxes, in its funding. This has always been important but becomes all the more so when a catastrophic provision is added. The costs of catastrophic need to be spread over the largest possible base of participants.

E. ALTERNATIVE APPROACHES TO CONSIDER

We believe that organizations like the Washington Business Group on Health have a responsibility to go beyond providing commentary on the proposals of others. In this spirit, we offer several ideas for your consideration.

These are not WBGH membership positions. They are ideas, in various stages of examination, which are relevant to the topic of this hearing. We hope they are of some use and welcome whatever criticism they may stimulate. Some possible efforts might include:

1. Require evidence of catastrophic insurance for the issuance of a drivers license, hunters license, pilots license, sky divers and hang gliders permit etc.
2. Consider making Medicare more of a need-based program. If Congress or future Administrations are to be serious about the deficit then new revenues will have to be raised to maintain social services. No matter what the 1965 goal, the reality today is that we have many millionaires on Medicare and many more whose income leaves them totally capable of buying health insurance. Saying this does not distract from the reality of millions of elderly in need of assistance, it only makes more clear the need to have future public revenues targeted at those most in need.

There are two approaches which could be considered:

- A. Means test Medicare exactly like the rest of Social Security.
- B. Create "Medicare II", the catastrophic benefit only, and make this the only benefit available as an entitlement to people whose annual income or networth exceeds a predetermined level. They could be given the option of paying an annual premium that would be set to meet actuarial standards just like commercial competitors, but would have the advantage of automatic acceptance with no preexisting condition clauses and no marketing overhead to finance.
3. Investigate Medicare's possible role in the provision of long term care services. We can all agree that the vast majority of the elderly who face financial catastrophe do so for lack of long term care insurance rather than coverage for acute care. Why not have Medicare meet the demand/need of the elderly...its market?

Those eligible for Medicare could be given an option:

- A. Catastrophic with Parts A & B, as now proposed, or
- B. Catastrophic with a comprehensive LTC plan but no Parts A or B.

The economics of this proposal need careful scrutiny but there is considerable logic in having the federal plan provide what most of its participants need.

Such a plan would leave the private sector to offer "medigap" front end coverage more typical of normal private plans. And, Medicaid would find its state and federal burden for LTC considerably reduced thus easing the way to more reasonable and uniform poverty levels of eligibility and more dollars available for preventive services.

Other useful ideas to consider include mechanisms for stimulating the development or privately financed long term care services.

4. In the final analysis, the issue before you today is one of federalism: what segment of our society should be assigned responsibility for the health care financing of which population group? As long as we seek progress only by tinkering with the current design, the longer it will be before we face up to the generic federalism issue. Our goal should be to design an efficient, understandable, accessible and economical system that fits the needs of our population into the 21st century. We could, for example:
 - A. Have the federal government be responsible for all health care for those aged 72 and beyond. This would be a truly comprehensive plan of basic, acute, chronic LTC, and catastrophic protection. Perhaps the age will need to be 71 or 74...the point is that there is a cutoff beyond which everyone would know the federal plan was their total system.
 - B. Employers would have to provide a national standard minimal benefit package and catastrophic for all workers and immediate dependents but would not be responsible for any retirees over 72. This plan would be portable. The plan would be tax deductible and a condition of doing business. This plan would preempt all existing state and federal benefit mandates. Employers would be free to add to the basic plan as a normal function of negotiated compensation. Additions would be taxable to the employee. Retirees younger than 72 would be required to buy a conversion plan from their employer for which the employer would be obligated to contribute no more than 25 percent. They could also buy into the state plans or purchase commercial insurance products sold independently or through groups like AARP.
 - C. States would be assigned responsibility for the poor. No state could make eligibility requirements less than the federal poverty level but any state could go above that level, for example, for prenatal care. A Medicaid-type plan would be established with a set of basic benefits that could not be reduced but could be expanded. The increase cost to the states of the required uniformity would be offset by not having any of the poor over 65 in their sector of responsibility. This would also make it possible for states to do more structured purchasing of services for the poor because the needs would be far more homogeneous without the elderly in the plan.
 - D. Counties would be the remaining sector with a major responsibility. There are over 3000 counties and most have existing health systems, many with hospitals, that are often a dumping ground for those turned away by private institutions. In their new allocations of

responsibility, people don't get turned away because their source of reimbursement is clear (federal, employer or state). Counties would have two major tasks: public health with a focus on preventive services and to be the "safety net" for anyone who falls, temporarily, through the federal, state, employer system. An example would be an employer or HMO that went bankrupt. Persons covered under those plans would automatically be protected by the county system until their situation was resolved through courts, new employment etc.

This entire plan can be designed to foster competition based on quality as well as price and can be made easy to understand by the consumer. The entire system uses private sector providers and insurance principles.

The point here is not to suggest that this is a perfect option -- or even a very good one -- but rather to say we need to look for major system changes that lead to complete and affordable protection with a reasonable allocation of responsibility among the sectors of our society.

CONCLUSION

The catastrophic proposals before us will not bring "peace of mind" to all elderly Americans, as some have claimed. However, that reality should not cloud another reality: acute care catastrophic is needed and will form the building block for a new private/public effort to establish the more comprehensive, competitive and cost effective long term system we all know is needed.

Prepared by:
Willis B. Goldbeck
Carol Cronin
Cathy Amkraut
Robert Levin

Chairman STARK. Thank you, Mr. Goldbeck.

Mr. Ferrara, may I ask you to proceed? In about 5 or 6 minutes we are going to have to recess for about 15 minutes. If we can ask the witnesses to wait a few minutes, we will then come back and inquire. So if we suddenly have to dash out of here just to make a vote, we will let you finish when we return. Why don't you proceed.

**STATEMENT OF PETER J. FERRARA, POLICY ANALYST,
HERITAGE FOUNDATION, AND CATO INSTITUTE**

Mr. FERRARA. Thank you, Mr. Chairman.

I would like to use my time to summarize some of the main points in my written testimony.

First, the real policy problems in regard to catastrophic health. Between Medicare, Medicaid, and the private insurance, the elderly are basically covered for catastrophic expenses for acute care. Though expenses for such care can still be a big burden, there is no reason for an elderly person today to have substantial life savings wiped out by such expenses.

Those with such savings have the resources to purchase the private insurance that would prevent this from happening. Those without such resources can rely on Medicaid without the problem of having to lose life savings to do so.

The policy focus in this area should be to extend the private coverage as broadly as possible. The current role for the private sector may not be ideal and it may be desirable to reform Medicare to create a more rationalized role for the private sector, but the Government clearly cannot do it all.

Medicare already only pays for about 50 percent of the medical expenses of the elderly and the program faces a dramatic long-term financing crisis which indicates it will not even be able to do this. There needs to be a major role for the private sector and policy-makers need to focus on what that role should be.

The real problem for the elderly is not catastrophic acute care but long-term care. Neither Medicare or private insurance generally cover such expenses. The private insurers are starting to get into the long-term care market. The policy here should be aimed at encouraging the expansion of private insurance so that the elderly will have a vehicle to avoid catastrophic long-term care expenses without having their life savings wiped out. Another goal should be to offer savings vehicles during working years to make it easier for workers to develop savings available to purchase long-term care insurance in retirement.

Potentially the biggest problem of all for the elderly in regard to health care is in fact the financial crisis of Medicare. According to the latest Government reports, Medicare will likely run short of funds to pay promised benefits by the mid-1990s, and the long-term financing gap of Medicare is already 50 percent greater than the long-term financing gap of Social Security during the 1983 financing crisis. This problem needs to be addressed now so that rational reforms will have sufficient time to work.

For those under 65, close to 90 percent already have health insurance through the private sector, and the great majority of these

are already covered catastrophic expenses for acute care. The policy here should be focused on ensuring that present coverage includes at least minimum catastrophic elements and to develop mechanisms to extend coverage to the presently uninsured. And for those of all ages another big problem is still rapidly rising health care costs which needs to be addressed by restoring incentives through the private sector.

Now in response to these problems, there has been offered a number of proposals that would expand Medicare, including Secretary Bowen's proposal and the Stark-Gradison proposal. In my opinion, these proposals will not solve any real problems facing the elderly. They would basically just take over the insurance coverage the elderly already have in the private sector and put it in the public sector under Medicare.

There are a number of health insurance gaps not covered by Medicare or the private sector which trouble the elderly. There is lack of coverage for long-term nursing home care. There is lack of coverage for doctor's charges above the Medicare-approved fees. There is lack of coverage for prescription drugs, eye glasses, hearing aids and similar items.

But neither the Bowen proposal nor the Stark-Gradison proposal would seem to cover any of these gaps to any significant extent. They would consequently provide no real benefits to the elderly. They certainly would not prove an annual cap of \$2,000 or so on medical expenses for the elderly because of all the major uncovered gaps that would remain.

Under these proposals, the elderly may in fact end up with less coverage than they have today. It is doubtful that private policies would continue to be sold just to cover the first \$1,500 or \$2,000 in Medicare deductible and coinsurance fees which is all of their present coverage that they would have left under these proposals.

If the private policies are unable to continue, then the elderly will lose coverage which they have now. If the private policies do continue to be sold to cover remaining gaps left by Medicare, there would be no possible benefit to the elderly from the Medicare expansion plans. The elderly would still bear the cost of purchasing the private policies and would just pay more in public premiums or taxes and less in private premiums.

Moreover, under the Bowen proposal, the Medicare part B premiums may be raised so much over the long run that some of the elderly with marginal incomes may drop out of Medicare part B altogether.

Finally, under the Stark-Gradison proposal, income tax revenues would apparently be used to fund Medicare part A for the first time. This seems to provide an opening for using general revenues to cover the enormous part A long-term financing gap which would result in a huge drain on the Federal Treasury.

As an alternative to this Medicare expansion approach, I have offered in my testimony a nine point package which covers a whole range of real problems and policy goals regarding catastrophic coverage. They cover catastrophic acute and long-term care. They cover the young and the elderly. They cover the Medicare financing crisis and rising health care costs.

Seven of nine of these proposal are basically revenue neutral and the eighth, which is reversal of DEFRA have to be addressed. These are all spelled out in my written testimony, but they include minimum standards for private Medicare supplemental policies, vouchers for Medicare supplemental policies, overall Medicare vouchers, promotion of long-term care insurance, minimum standards for private employer health coverage, a health bank program, State uninsurable risk pools, reversing DEFRA and under a proposal advanced by Congressman Slaughter, providing today's young workers with the opportunity to substitute private savings and insurance for future Medicare coverage which would address the long-term Medicare financing crisis without raising taxes or cutting benefits, and it is the most positive approach to that issue that I have seen anywhere.

That summarizes my remarks and I will be glad to answer any questions.

[Statement of Mr. Ferrara follows:]

Catastrophic Health Costs: Private Sector Solutions

By
Peter J. Ferrara

Testimony before the Subcommittee on Health
of the Committee on Ways and Means
U.S. House of Representatives
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Summary

Both the Administration and Congress are focusing on policy options for addressing catastrophic health cost concerns. Protection of American citizens from catastrophic health expenses is an important public policy goal, which can and should be achieved by government policies that facilitate private sector solutions.

Between Medicare, Medicaid and private insurance, the elderly are basically covered for catastrophic expenses for acute care by doctors and hospitals. But policies to extend private coverage for these expenses as broadly as possible would be desirable. The real problem for the elderly, however, is long term care in nursing homes or other settings, which is mostly uncovered by Medicare or the private sector. The potentially biggest problem of all for the elderly is that Medicare will probably fall into bankruptcy by the mid-1990s, with an enormous long term financing gap. For those under 65, the main issues are ensuring that the coverage which already exists for the great majority includes catastrophic protection, and extending coverage to those who are presently uninsured. Young and old still face the problem of rapidly rising health care costs in real terms.

Simply expanding Medicare to take over coverage already provided by the private sector, as many in Congress seem anxious to do, would not solve any of these problems and would provide no real benefit for the elderly. Instead, much can be accomplished through private sector oriented proposals, most of which would cost the Federal government little or nothing in terms of increased spending or lost revenue.

Policy Problems and Goals

Medicare Part A (Hospital Insurance or HI) pays for up to 90 days of inpatient hospital care for each spell of illness, with 60 additional lifetime reserve days each individual can use once at any time. This coverage is subject to a deductible of \$520 per hospital stay, plus co-insurance fees of \$130 per day for the 61st to 90th days of hospital stay, and \$260 for each lifetime reserve day. Medicare Part B (Supplementary Medical Insurance or SMI) pays for physician or other health related services, subject to an annual deductible of \$75 and a co-insurance fee equal to 20% of approved charges. Part A or HI is financed by a portion of the payroll tax, while Part B or SMI is financed by a monthly premium of \$17.90 charged to each elderly beneficiary, which pays for about 25% of program costs, and by general revenues. The Medicare deductibles, co-insurance fees and premiums (except the \$75 Part B deductible) are indexed to increase with health inflation each year.

Over 70% of the elderly also have supplemental health coverage which generally insures against the Part A deductible fee of \$520, the Part A and Part B co-insurance fees, and 365 days of

hospital care beyond Medicare's coverage. This coverage is provided to the elderly through Blue Cross/Blue Shield, the major elderly groups such as the American Association of Retired Persons (AARP) and the National Council of Senior Citizens (NCSC), over 200 insurance companies, HMOs, and group coverage provided by former employers as part of pension benefits. Over half of the rest of the elderly are already covered by Medicaid.

Consequently, between Medicare, Medicaid and the private insurance, the elderly are basically covered for catastrophic expenses for acute care, which is care provided by doctors and hospitals for specific illnesses. Though their share of expenses for such care can still be a big burden, there is no reason for an elderly person today to have substantial life savings wiped out by such expenses. Those with such savings have the resources to purchase the private insurance that would prevent this from happening. Those who do not have such resources are currently or ultimately backed up by Medicaid. The policy focus in this area should be to extend the private coverage as broadly as possible.

The current role of the private insurance for those over 65 grew unexpectedly. The Medicare deductible and co-insurance fees were originally intended as devices to discourage the elderly from overutilizing medical care given their Medicare coverage, and to perform this function such fees need to remain uninsured. But over the years these fees have grown too large to perform their original function. The hospital deductible and co-insurance fees alone can grow to \$20,000 before Medicare coverage runs out, with 20% of doctor's fees and related services to be paid as well. The elderly now need insurance against such costs.

The development of this private insurance should be seen as quite positive, since it shows the ability and willingness of the private sector to provide health insurance for the elderly. The current role for the private sector in providing such coverage may not be ideal. It may be desirable to reform Medicare to create a more rationalized role for private health insurance. Many feel that the current system of health coverage for the elderly is indeed inverted. Rather than the government covering the bulk of expenses mostly up front, and the private sector performing a limited, back-up, catastrophic role, many feel it should be just the opposite. But there is no sound reason for simply expanding Medicare to take over some or all of the current role of the private sector. The government can't do it all. Medicare covers only about 50% of the medical expenses of the elderly, and faces a dramatic long term financing crisis which indicates it will not even be able to do this. There needs to be a major role for the private sector.

The big problem for the elderly is not catastrophic acute care expenses, but expenses for long term care in nursing homes or other settings. Neither Medicare nor the private insurance generally covers such long term care expenses. Many private insurers are beginning to offer such coverage with enthusiasm, but very few of the elderly have such coverage today. Nursing home expenses are quite high, usually between \$1,500 and \$3,000 per month, and such costs can soon deplete the life savings of most of the elderly, leaving the burden on children or other relatives, or on Medicaid. Yet, it would be far too expensive for the government simply to pick up all such expenses, increasing Federal spending by probably close to \$20 billion per year to start. Policy should be aimed at expanding the availability of

long term care insurance, so the elderly need not face the risk of having life savings destroyed by debilitating sickness near the end of life. Another goal should be to offer vehicles during working years to make it easier for workers to develop savings which will be available to purchase long term care insurance in retirement.

The potentially biggest problem of all is lurking just around the corner - the Medicare financing crisis. According to the annual Trustee's reports, Medicare will likely run short of funds by the mid-1990s. The long term financing gap for Medicare is now much greater than the long term gap faced by Social Security before the crisis bail out amendments of 1983. Paying all the Medicare benefits promised to today's young workers would likely require raising Medicare payroll taxes 250% to 500%. This problem needs to be addressed now so that rational reforms will have sufficient time to work. If action is delayed until the last minute, then the only options will be sharp payroll tax increases or draconian benefit cuts.

For those under 65, around 90% already have health insurance coverage through the private sector or Medicaid. The great majority of these have catastrophic coverage for acute care expenses in their current insurance. One issue here is to ensure that all present coverage includes at least minimum catastrophic elements. Another is to develop mechanisms to extend coverage to the presently uninsured.

Both young and old face the problem of still rapidly rising health care costs in real terms. This problem needs to be addressed by restoring incentives to conserve medical resources.

The Medicare Expansion Approach

Health and Human Services Secretary Otis Bowen, proposes to expand Medicare to cover all current deductible and co-insurance fees, except the first \$2,000 in such expenses each year, and unlimited days of hospital care. This extra coverage would be financed by increasing the Medicare premium sufficiently to cover the increased costs. HHS estimates that an increase of \$4.92 per month in the premium would be required in the first year, amounting to a 30% increase in Medicare premiums for the elderly, following a 15% increase which took effect January 1. The Congressional Budget Office estimates that the premium increase would have to be \$6.40 per month to start, amounting to a 36% increase on current premiums for the elderly. Congressman Fortney Stark (D.-Ca.) and William Gradison (R.-Ohio) propose alternatively to provide slightly greater coverage, excepting only the first \$1,000 of Part B co-insurance fees and two Part A hospitalization deductibles each year. This coverage would be financed not by increasing Medicare premiums, but rather increasing income taxes on the elderly and using the funds for the new Medicare benefits.

Despite intentions, these proposals will not solve any real problems facing the elderly. They would basically just take over insurance coverage the elderly already have in the private sector and put it in the public sector under Medicare. They would in fact take over all of the coverage of the private policies as described above except the first \$2,000 or so in covered expenses each year.

There are a number of health insurance gaps not covered by Medicare or the private sector which trouble the elderly. Besides the lack of coverage for long term care as described above, the elderly are also generally uncovered for doctor's charges above the maximum fees Medicare will reimburse (which are significantly below the fees most doctors charge) as well as most prescription drugs, eyeglasses, hearing aids, and similar items. But neither the Bowen proposal nor Stark/Gradison would cover any of these gaps. They would consequently provide no real benefit to the elderly. They would certainly not provide an annual cap of \$2,000 or so on medical expenses for the elderly, because of all the major uncovered gaps that would remain. These proposals also offer nothing to address the long term Medicare financing crisis or rapidly rising health care costs.

Many note that the private policies cost substantially more than Bowen's proposed coverage for now \$77 per year. But the private policies cover most or all of the first \$2,000 in expenses that Bowen's plan would not cover. Since there is a relatively high probability that a retiree will incur some or all of such up front costs each year, these costs are quite expensive to cover. Requirements under the Baucus Amendment mandate that the private policies include most of this up-front coverage. These requirements could be modified to allow private insurers to offer policies with higher deductibles and lower costs.

Both proposals would offer unlimited coverage while the private policies are often subject to caps of 365 days of hospital care and \$5,000 of expenses on the Medicare Part B 20% co-insurance fee. But as a practical matter virtually no one ever exceeds the limits of the private policies. To exceed the hospitalization coverage, for example, would require hospitalization of 516 days for a single spell of illness (if no prior hospitalization in retirement exceeded 90 days, itself an extremely rare occurrence). Moreover, the existing Baucus requirements could again be changed to require unlimited coverage for the private policies. Since virtually no one ever exceeds the current limits, the insurers have said they would support such a change and would not even need to increase their premiums as a result. Indeed, many private policies already offer unlimited coverage for the Part B 20% co-insurance fee.

Under the proposed Medicare expansion plans, the elderly may well end up with less coverage than they have today. It is doubtful that private policies would continue to be sold just to cover the first \$2,000 in Medicare deductible and co-insurance fees, which is all of their present coverage they would have left. If the private policies are unable to continue, then the elderly will lose this coverage which they have now. With the private sector completely forced out, the elderly will be left at the mercy of a government monopoly under Medicare with no outlet to compensate for inadequate coverage or services. However, if the private policies continue to be sold to cover remaining gaps left by Medicare, there would be no possible benefit to the elderly from the Medicare expansion plans. They would still bear the costs of purchasing the private policies, and would just pay more in public premiums or taxes and less in private premiums. Moreover, under the Bowen proposal, Medicare Part B premiums may be increased so much that some of the elderly with marginal incomes may drop out of Part B altogether.

Finally, under Stark/Gradison income tax revenues would be used to fund Medicare Part A for the first time. This seems to

provide an opening for using general revenues to cover the enormous Part A long term financing gap, which would result in a huge drain on the Federal Treasury.

Private Sector Options

There are a wide range of policy options which address the real catastrophic health care issues by adopting government policies which facilitate the development of necessary insurance coverage and resources through the private sector.^{1/} A comprehensive package of such options which together address the problems of young and old, the short term and the long term, is described below.

Cost-Neutral Proposals. A lot can be done through a number of options which would cost the Federal government little or nothing in terms of increased spending or lost revenues. These include:

1. Minimum Standards for Medicare Supplemental Policies. The Federal Baucus Amendment and companion state regulations set minimum standards for the private policies sold to the elderly to supplement Medicare. As noted above, these standards could be modified to require that the policies include coverage for unlimited days of hospital care after Medicare runs out, and for unlimited expenses for the Medicare Part B 20% co-insurance fee. Since virtually no one ever exceeds the current policy limits, the insurers have stated that this change would require no change in their premiums, and that they would support it. The change would enhance confidence that these private policies provide complete catastrophic acute care protection. As also noted above, the Baucus standards could be modified to allow insurers to offer catastrophic only policies with higher deductibles. These policies would cost less than currently available policies, and this could lead even more of the elderly to purchase private insurance protection.

2. Vouchers for Medicare Supplemental Policies. This reform of the private policies could be extended to provide vouchers to the elderly not on Medicaid which could be used towards the premiums of private Medicare supplemental policies including minimum catastrophic elements. The voucher would provide each elderly retiree with \$60 per year towards such premiums, and Medicare deductible and co-insurance fees could be raised to provide the funds for the vouchers, with the private policies covering these increased fees as well. The voucher system could be modified after the Federal employee health benefits system, with each elderly beneficiary receiving a form listing the private policies which are eligible for the voucher. The elderly could then mark their choice and provide whatever additional funds are needed to purchase policies offering more than just catastrophic coverage. This voucher system would extend private coverage to more of the elderly.

3. Medicare Vouchers. Under a recently adopted initiative, Medicare beneficiaries now have the option of choosing a Health Maintenance Organization (HMO) to provide their Medicare

1/ See Private Sector Task Force on Catastrophic and Long-Term Health Care, Catastrophic and Long-Term Health Care: Private Sector Alternatives (Wash., D.C.: National Chamber Foundation, 1986).

coverage. The chosen HMO receives from the Federal government 95% of the cost of an average Medicare beneficiary each year. In accordance with Federal requirements, and to attract elderly customers under the program, virtually all HMOs are now offering catastrophic acute care coverage without charge to retirees who sign up with the HMO to provide their Medicare coverage.

This option could be expanded into a full-fledged voucher system for Medicare, with retirees free to choose to have their Medicare coverage provided by any qualified insurer, including HMOs, former employers as part of pension coverage, and regular insurance companies. Each insurer would be required to provide acute care catastrophic coverage without charge to each retiree which chose the insurer to provide Medicare coverage. This would help the elderly to obtain catastrophic coverage at less expense, and reduce rapidly rising health care costs. It would also help to extend private catastrophic coverage to more of the elderly.

4. Long-Term Care Insurance. The private sector today provides little insurance to cover long term care, but companies are starting to offer such coverage more and more. The Federal government should conduct studies and provide technical assistance to promote the development of such insurance. It should conduct educational campaigns among the elderly concerning the need for such coverage, as surveys show that most of the elderly erroneously believe Medicare provides such coverage. It should also consult more closely with the private insurers and help to remove any unnecessary government imposed barriers to the development of such insurance which may exist. Draft legislation developed by Rep. Hal Daub (R.-Neb.) would also serve to make private long term care insurance more available. Greater availability of this insurance would help today's elderly to cope with long term care expenses.

5. Minimum Standards for Employer Coverage. Health insurance for those below 65 is primarily obtained through group coverage provided by employers, who receive a tax deduction for the premiums. This tax deduction should be modified to be available only for insurance that includes a minimum degree of coverage against catastrophic illnesses. This should result in little or no extra cost to employers, because the small probability of any individual worker incurring catastrophic expenses makes catastrophic coverage inexpensive. A slight increase in front-end deductible or co-insurance fees would provide sufficient savings to the employer to offset the cost of the catastrophic coverage. The vast majority of employer sponsored protection already includes catastrophic coverage, so no extra cost would result in these cases in any event. The lack of such coverage in employer insurance is usually due simply to oversight or unsophistication. This policy option would extend catastrophic protection for those under 65.

6. Health Banks. The tax deduction for employer provided insurance could be further modified so that workers individually or their employers could make tax deductible contributions to a Health Bank instead of purchasing health insurance directly. Health bank funds would be used to buy catastrophic only health policies with high annual deductibles of \$1,000 or more, and to pay health expenses under the deductible directly. Since catastrophic only policies are so much less expensive than policies with front-end coverage, substantial savings could build up in the account after payment of the catastrophic only premiums. Any funds remaining after 65 could be used for retirement health insurance or medical expenses, including long term care.

This would help to restore incentives to counter rapidly rising health costs. Workers would seek more vigorously to avoid unnecessary or overly expensive medical charges for at least more routine medical expenses, since they would not have third party payment for such expenses and would want to conserve their Health Bank savings. To the extent workers and employers substitute Health Banks for existing first dollar coverage, there would be no net revenue loss from this option. The Health Banks, however, also provide a new vehicle for the uninsured to obtain coverage. A worker whose employer provided no coverage could make tax deductible contributions to the Health Bank on his own, and use the funds to buy catastrophic only policies. This option should consequently help to extend coverage to many of the uninsured under 65. To the extent this occurs, there would be some modest additional revenue loss, but this would all be due to the new coverage of the presently uninsured, through a vehicle enabling them to participate in a benefit most others now enjoy.

7. State Uninsurable Risk Pools. States have already begun to set up uninsurable risk pools, under which all insurers in the state contribute to a pool which offers insurance to otherwise uninsurable individuals, both young and old. The premiums are set at 150%-200% of the usual market fees, which still leaves a financing gap which must be met out of insurer contributions to the pool. This would allow uninsurable individuals to have insurance financed by their own premiums to the maximum reasonable degree, minimizing subsidies from the general public.

The Federal government could encourage all states to set up such pools. ERISA may have to be amended to allow states to include self-insurers in the pool. But the idea of imposing the costs only on insurers should be reevaluated. This cost will be reflected in regular premiums, and may consequently lead to less insurance coverage among the general population. The pool subsidies are a public responsibility and consequently would best be financed by the broadest possible revenue sources. Moreover, pool insurance premiums should be kept well above market rates, and insurance from the pool should be strictly limited to those who cannot obtain insurance anywhere else, to avoid any possibility that the state fund might displace private insurance. Pool insurance should also have a high front-end deductible to minimize the needed subsidy, while still providing essential coverage.

Long Term Proposals. Other private sector options would result in significant revenue losses in the short term, but would have very substantial impacts over the long run that would be well worth the costs. These options include:

8. Reverse DEFRA. In the Deficit Reduction Act of 1984 (DEFRA), the law was changed so that companies could not take deductions for contributions to a fund during working years to pay for retirement health coverage, as they are allowed to do for pension benefits. As a result, companies offering retirement health benefits would now have to carry growing liabilities on their balance sheets representing the future obligation to pay the benefits, but could not develop assets to offset those liabilities because the cost of doing so would not be treated as a business expense.

This short sighted tax policy is strongly discouraging employers from providing retirement health benefits for their employees and should be reversed. Employers should be allowed a

deduction up to some reasonable limit for contributions to prefund catastrophic acute care coverage and long term care coverage for the retirement years of their current employees. This should strongly increase such coverage among retirees in the future.

9. Health Care Savings Accounts. The option which will have the most dramatic effect over the long run was embodied last year in bipartisan legislation spearheaded by Rep. French Slaughter (R.-Va.), which will be reintroduced this year. Under this legislation, workers and their employers could contribute to private Health Care Savings Accounts in return for income tax credits. To the extent such contributions were made to a worker's account, that worker would have an added annual deductible under Medicare, potentially amounting to several thousand dollars per year. The worker could then use the funds in his account to purchase private health insurance and/or pay his medical expenses below the deductible directly.

If a worker exercised the account option to a minimum degree throughout his career, he would receive catastrophic acute care coverage under Medicare for medical expenses above his added annual deductible. Funds in the account would be available for long term care expenses. If a retiree spent less than a specified proportion of funds in his account each year on medical expenses or insurance, he could withdraw the difference at the end of the year without restriction.

This option would address catastrophic and long term care issues for the elderly. Indeed, it would reverse the inverted priorities of Medicare for those who exercised the option, allowing the private sector responsibility for the great majority of health expenses for the elderly focused on the front-end costs, and reserving the back-up catastrophic role for the government.

The private accounts would also create strong new incentives to counter rapidly rising health care costs. Retirees would likely seek to avoid expensive first dollar insurance coverage and unnecessary or overly expensive medical charges to retain greater reserves in their private accounts and even pay themselves cash rebates.

Most importantly of all, the long term Medicare financing crisis would be sharply reduced and potentially eliminated altogether through this option, in a purely positive manner without cutting benefits for the elderly or increasing payroll taxes for workers. Since workers receive an income tax credit for their contributions, Medicare payroll tax revenues are not reduced. But Medicare spending would be sharply reduced by the increased deductibles, as workers relied more on their private sector accounts and less on Medicare. With revenues maintained and spending reduced, the long term financing gap would be reduced and possibly eliminated if enough workers exercised the option soon enough. Over the long run, as much as 80% of Medicare on net would be shifted to the private sector through this option, reducing Medicare spending by 80% as a result.

Conclusion

The above proposals are offered together as a comprehensive package to address the whole range of catastrophic health care issues. These proposals show that addressing catastrophic health care needs does not require a further expansion of rigid big government programs. Indeed, that will only make problems worse. The real problems can best be solved by adoption of the proposed government policies which will facilitate solutions through a competitive, decentralized, flexible, private sector framework.

Chairman STARK. Thank you very much.

Mr. DAUB. He ought to get a medal, Mr. Chairman.

Chairman STARK. The committee will recess for 15 minutes.

Mr. DAUB. We will be right back.

[Recess.]

Chairman STARK. Mr. Daub is on his way. I want to thank the panel for their indulgence. We do this every once in a while just so we don't forget how to vote.

I guess, if I understand the testimony of the AFL-CIO, Ms. Ignagni, really your major quarrel is with the financing and that's because of the scepter of taxing fringe benefits. And I presume that if I could find some way to assure you that we would never ever tax fringe benefits, I'd get your forbearance.

Ms. IGNAGNI. Mr. Chairman, is it permissible to take the fifth in this committee?

Chairman STARK. But let me suggest, and here's my only problem. I have really no quarrel. Again, I think that taxing fringe benefits is a different issue. This is what I'd argue with you all, is that you're talking about a private benefit. That's something that you and the employers negotiate and it comes out of the employers' pocket or your workers' pocket. Foregoing wages or the employer increasing his or her expense has very little to do with the Federal Government. There is some tax freedom in it.

In our eyes, we are really paying a good chunk of it via in part B, we're paying 75 percent of it, I mean, just a big chunk of Federal benefits, and I would submit to you that that's different. It's almost the same in the tax free portion of the FICA benefit in that it's deductible to the employer, and the beneficiary isn't paying for it, but it still is a little bit different.

And so we have no grief with it if we could figure out a way to make the payment system progressive. And I would thank you all if we could find a way.

Now, as to your own system, here's the problem I see, and correct me if I'm wrong, please. One of the problems with a refundable tax credit, aside from the fact that I love them in general, is that they have some fears about returning to Nixon's fat plan. In other words, you're talking about a guaranteed annual income almost when you start talking to some people about it. It was, I might add, a Nixon program, but the other thing is that about 65 percent of the 30 million American Medicare beneficiaries don't file a tax return.

And that's the key. Look at it this way: if they receive a tax credit and they paid under Bowen's plan, \$72 a year in the first year, we think, and it costs them \$50 to go to H&R Block and fill out the return to get the \$72 back. Plus the fact that I wonder if the fear of a complex system, whether it's a new W4 or—well, they wouldn't do that—but a tax return wouldn't really deny it to them. I don't even want to get into the question of whether some of those folks who aren't filing returns maybe ought to be filing them.

So with that, you have some real problems there. If we could find a different way, I would have no quarrel. And believe me, the committee, not only myself and Mr. Gradison, but the other members, have wrestled with this for a couple years. It's because we brought this same proposal up in effect last year or last Congress.

We thought of relating the premium to the Social Security benefit check, which generally would parallel previous earnings. But unfortunately this is not true in all cases, so you'd always bring up the horror story of someone who only gets a \$400 Social Security check, but just received a million dollar trust fund that they inherited from somebody. In other words, they got a very small Social Security benefit but they are millionaires, and we'd be exempting them.

So I would hope that we could find a way to convince you that we may end up with sort of a compromise. We may end up with some kind of a premium and some taxing. And I'm indifferent. I mean if the worst that happened to me in my lifetime is that we got more benefits and we got Mr. Bowen's premium, I'd sure sign up. But I'm hoping that we could make it more progressive and I would think the AFL-CIO would join me in that.

So I guess what I'm saying is we are so close to finding a start, I don't think it's any kind of solution, and I would join with all the witnesses who said, this is not the end of the world; this is just a first step, but it's the first practical step that we've made in the Medicare program in 10 years. We haven't done a whole hell of a lot to expand it. And I'm willing to do that and I certainly hope that I can do it with the help of organized labor.

And having said that, you're welcome to comment. I appreciate your support as far as it went. But I wish we could find a way to get your unqualified endorsement as I would wish for that from Mr. Goldbeck's group, but let me start with you and see if I can get your unqualified endorsement today. I'll work on Mr. Goldbeck next.

Ms. IGNAGNI. Well, I'm proceeding from my position that I'm taking the fifth. But I'll endeavor to do what I can to answer you directly. You've raised some very legitimate issues. And I do, for the record, want to clarify our position. We acknowledge your efforts to make this indeed a fair, equitable and progressive system that would be financed in the most sensible way. We share your concern which is why we just didn't want to come up here and say, no, to your proposal.

Chairman STARK. Thank you, really.

Ms. IGNAGNI. Which is why we endeavored to struggle with the earned income tax credit.

Now, I understand what you say about the point which is quite a legitimate one, that a number of elderly people don't now file tax returns and what are the costs versus the benefits. I do believe, and we've had some preliminary conversations with people at the IRS, that a very simple form could be filled out without a lot of redtape to provide this relief to senior citizens.

As an alternative, and we've also begun to discuss this issue with Social Security, it could very well be that the money would be sent back through the Social Security mechanism, through the checks, so that would be another thing which we would be willing to look at starting with the most——

Chairman STARK. Did you think about this one?

Ms. IGNAGNI. Yes?

Chairman STARK. And I hate to throw another one out at you, but you could adjust the deductible. We could require beneficiaries

to pay the first \$500. But if you can prove that you're low income, we'll waive the deductible. Now that tends to take the——

Ms. IGNAGNI. Excuse me. I don't believe—I think you've probably got a sensible idea in mind, but I don't believe from a technical standpoint that that's going to raise enough money. Because the deductible would be contingent upon the number of people who actually go into the hospital.

Chairman STARK. Yes, it probably would because two thirds of the people would qualify.

Ms. IGNAGNI. Right.

Chairman STARK. If you raised, and that's the biggest cost.

Ms. IGNAGNI. Right. But if you start talking about bringing in prescriptions and some of these other costs, then it's——

Chairman STARK. Oh, no. OK. I'm talking about just for the things we——

Ms. IGNAGNI. And as you know, we're——

Chairman STARK. Well, even prescriptions. I mean, with a little bit of luck and your support from your members that represent public employees, and if we add State and local employees into the pot as they probably well should be as 90 percent of your members would concur, we've got enough in there to make a good hit at prescriptions. Put a couple of dollars per prescription as an entry level, and place some kind of a copay in there, and we could take care of prescriptions for a reasonable amount of money.

The same thing actually is true in long term care if we eliminate the first 90 days, which sounds harsh. But, basically then you get to the real long term folks, and have some kind of definition as to who is sick and who is trying to dump their mother off to the Federal Government. If you could sort that out, you're probably only dealing with half a million people.

And those are affordable. The problem is the definitional distinctions are so tough and it would only translate into more money. If we pick up cigarette taxes or we pick up the profits that the hospitals ostensibly have been getting too much of because of DRGs, or if we pick up State and local, or if we quit the Star Wars system or something like that and get a lot of money from the Budget Committee, all of those things are pretty close.

And I admit we're starting a pattern here of how we would expand it. But I'm sure this committee would love to go forward on that. And so to that extent, you are right. What we do, if anything this year, will hopefully create a pattern that we can expand on. I wouldn't want anybody to think we're not thinking about that.

There's no question, I don't think any of the witnesses or members disagree on which benefits we would like to expand to cover. And I don't think anybody disagrees with that. The only question is, how do we pay for it.

Ms. IGNAGNI. I agree. And the point I wanted to leave with you is that we are prepared to work with you to develop and flesh out a number of various solutions that would be progressively financed. As you know, we do have some concerns about some of the proposals you've raised, but that does not preclude our talking and continuing the dialog with you, with staff, and others, to try to develop the most sensible system.

I would like to make the point—that's a general comment—in terms of the specifics, that when we talk about catastrophes and catastrophic needs for those who are elderly who even have medigap coverage, you know, very few of those plans provide coverage for prescription drugs, and for people who are chronically ill, indeed \$50 to \$100 a month in maintenance drug expenditures is quite a burden.

So we are very very interested in working with you to begin to deal with that.

Chairman STARK. I've got an idea. What if we said that we would put a tax on all fringe benefits of salaried and hourly wage employees in the United States, and put all of that into a trust fund, the income from which would be used exclusively to organize by organized labor. I would venture that you'd never get a nickel's worth of tax, because Mr. Goldbeck's group would see that that tax never came in. But if it ever did, you'd get it back, and we could put that aside forever. How's that?

Could you buy into that?

Ms. IGNAGNI. I'm going to take the fifth again on that, Mr. Chairman.

Chairman STARK. Mr. Goldbeck, would you expand a little bit. It's refreshing to see why business would like to extend the Medicare benefits. We've had some testimony from the AMA, for instance, that we ought to let the private sector do this all. Do you want to deal with that?

How do you square with those who feel that, given enough time, and enough incentive, the private insurance companies could do all this?

Mr. GOLDBECK. I'd be happy to address that question. We've reviewed the policies of the companies that are members of our organization. We have also tried to review the various offerings of the supplemental and the so-called medigap plans that are available and array those against the needs of people in the country.

As you stated at the outset, it's very clear that the majority of Medicare recipients find some combination of public and private plans to provide their coverage. The reality remains, nonetheless, that several hundred thousand do not. It seems reasonable that one of the roles of this committee is to have Medicare close that gap for those several hundred thousand people who are in significant need.

I think it's also useful to recognize that those several hundred thousand people are not a static group. Over time, the total becomes a great deal more as those who avoid health problems in one year fall victim in another. And, from the standpoint of the fear issue, a great many people who do not ever incur the acute care financially catastrophic event, nonetheless, live in fear that they will. This concern is so great, that they purchase multiple, contradictory and often duplicative medigap policies, wasting resources that could be devoted to long term care needs.

Whereas the private sector has done some things extremely well, it has not addressed this problem in its entirety. When you add to that the realities that you've delineated earlier about preexisting condition clauses, you have a very substantial problem. I'm not so sure that the loss ratio and other problems are quite as big an issue as they're made out to be. At the very least, they're ones that

could be technically corrected within the private sector, but the preexisting condition is not a small item by any stretch of the imagination.

When we look at our members, roughly 95 percent now provide catastrophic benefits to their retirees on a voluntary basis. So they're familiar with this line of business that you're thinking of getting into. They know the pitfalls. They also know that a great many of their suppliers don't provide comparable coverage, neither do a great many of the small businesses. Most employers do not provide anything for retirees, so that leaves out a whole cohort of the population. Given the trend to early—pre-65—retirement, this is a problem of growing magnitude.

You can't just talk about employment as though it was a dumping ground for those who would like to write a blank check for providers. It just doesn't happen to work out that way. I find it interesting that those who speak most forcefully against anything further being done by the Government, have no compunction whatsoever to suggest that the Government should immediately mandate everything on employers. An even worse problem is the pretense that such costs shifts are savings and are not the equivalent of taxes.

The WBGH finds more than enough justification for moving ahead on catastrophic, fully cognizant that it is not the sole answer to the problems.

Chairman STARK. Well, thank you very much. I appreciate that. It's refreshing to always see principle put ahead of profit, and thank you very much for your contribution.

Mr. Ferrara, you point out, and quite correctly I think, that the Medicare hospital insurance trust fund is going to face financial problems by the end of the century; could be by the end of the decade.

Do you have any suggestions as to first, what we might do to anticipate these long term problems and second, do you see anything we might change in our present legislation that would head some of those off at the pass?

Mr. FERRARA. Yes, I do, Mr. Congressman.

In the testimony as one of the options, I discuss, it's the ninth option, a bill that was introduced in the House of Representatives by Congressman Slaughter last session, and it's been reintroduced this session, and it had 40 cosponsors in the last session, including Republicans and Democrats, liberals and conservatives, and basically under that bill, workers along with their employers would be allowed to put aside funds during their working years in a health care savings account, in return for a 60 percent income tax credit for those contributions.

And to the extent that they exercise this option over their working years, when they retired, they would face a higher deductible under Medicare, but they could then use the funds in the private account to pay for their medical expenses directly, or to buy private insurance to cover expenses below the deductible.

For example, if you took a young worker entering the work force today, and he exercised this option each year of his entire career to the maximum, when he retired, he might have a deductible under Medicare of \$5,000, \$6,000. He's responsible for the first \$5,000 or

\$6,000 in his medical expenses. He may have \$75,000, \$80,000 in his health care savings account and he would use a portion of that to buy insurance to cover that first \$5,000 in expenses.

Through this approach, you're maintaining the revenues that go into Medicare because the rebate comes through the income tax system, but you're reducing Medicare expenses dramatically by the increased deductibles, and—

Chairman STARK. But aren't you actually just reducing your tax revenue by the same amount you're putting in? Why don't we just take some money out of general revenues and transfer it into the trust fund? You're kind of going the long way around the barn, aren't you?

Mr. FERRARA. Well, no, because this has the advantage of substituting private savings and insurance for part of the Medicare coverage and bringing in new incentives through the private sector to help people address rising health care costs. Bringing in—

Chairman STARK. I've got no quarrel with that, but the Treasury's paying for it.

Mr. FERRARA. Well, you must weigh the costs against benefits, we don't, you know, we don't hide that. You have a short term revenue loss from the income tax credit and the long term advantage is that you have a system over the long run where the Government performs its function which is the catastrophic role, and the private sector performs its function.

Chairman STARK. Well, what percentage of the population do you think could afford to participate in that?

Mr. FERRARA. Eighty, 90, 95 percent. That's what we have in mind.

Chairman STARK. Could afford it?

Mr. FERRARA. Well, because this is based—there's two factors here on this. One is that you get a 60 percent income tax credit, that is, you get 60 cents back for every dollar that's put into this account. And if you need it, you can withdraw the other 40 percent from the account like a regular IRA, so there's a very minimal immediate cash flow burden on the worker for exercising the account.

Second, this thing is designed so that the employer joins in with the worker and makes the contributions, like with pension systems which have very broad coverage. And maybe it should even more appropriately be called health pension accounts. So between these factors of the income tax credit and the employer role, we think this has a great opportunity for very broad based participation, and the bill was offered in that spirit.

I mean we would not be interested in this if it was just going to be a small percentage of the population that was going to exercise it. This is meant to be a program that ultimately almost everybody participates in.

Chairman STARK. What do you do with the people who can't afford it, which I suspect may be probably 20 to 30 million Americans who don't have enough money to have food and shelter. Where are they going to get the money to participate?

Mr. FERRARA. Well, if you don't go into this, you're still on Medicare and you still have Medicaid to back you up. If you're a poor person then you know, Medicaid performs the function, particularly if you're elderly, Medicaid performs the function of backing you

up. You don't have to worry about having your lifesavings wiped out to be on Medicaid if you're poor, because you don't have lifesavings if you're poor.

Chairman STARK. That's right.

OK, well I appreciate the panel's patience. I'm sorry that you got caught by this vote. I look forward to working with you over the next several——

Mr. FERRARA. Mr. Chairman?

Chairman STARK. Yes?

Mr. FERRARA. Can I make a point, raise an issue, a point about an issue that arose earlier? You raised a question about the exclusion of preexisting conditions under the private policies.

Chairman STARK. Yes.

Mr. FERRARA. And I'd like to address that. I've talked to a number of private insurers about this particular issue. And what the private insurers tell me is that the way they work on preexisting conditions is that they exclude the coverage for a period of like 6, such as 6 months to a year, after which they would then cover health costs related to that condition.

And this is to address the problem which any insurance company faces. You can't have a guy wait until he's sick, and then walk in the door and say, now I want to buy the insurance. So this is a mechanism to get around that, but it's not like they're never covered on that.

Chairman STARK. In reality, it's sort of is like they are never covered, but I guess the question is, shouldn't our health programs be, by nature, designed mostly to help the sick people? I mean, so it is your fault if you have diabetes and should you be excluded, shouldn't you really, shouldn't we go the other way? We should take a special step for the hemophiliacs, diabetics or the epileptics. They probably all support Jerry Falwell and Pat Buchanan and President Reagan, and so have done nothing in their lives to deserve having these diseases, yet, they're there, and it seems to me that almost by definition, they ought to be the first ones we help.

Mr. FERRARA. We have to draw a distinction there. I mean, if you're completely uninsurable and one of the points in my testimony is to promote the state uninsurable risk pools.

Chairman STARK. Great.

Mr. FERRARA. And so there's that issue.

Now, I left something out in describing the private situation. Not only is the noncoverage limited for a period of 6 months to a year, but it only applies to preexisting conditions which have been active in a short period just before the insurance coverage, like 6 months to a year just before the coverage. And the idea is you just can't have any insurance program where you just say, well you can walk in after you get sick and then pay the premium. And so——

Chairman STARK. We have it in Medicare.

Mr. FERRARA [continuing]. Because of these two factors, it's a very limited, it's a very limited issue. It's only for things that have been active in the past 6 months to a year, and it only excludes coverage for 6 months to a year. I haven't seen any studies that say that this is in fact a major problem. I think that because of the limitations on it, it's a very limited problem.

Chairman STARK. Well, as limited as it may be, let's just lump it in with our Federal program. Nobody ought to mind. The insurers can go on and find a whole bunch of things to insure, and if I thought for a minute that the insurance companies would be out of business or stop finding things to insure, if I thought I was going to deny anybody the chance to watch Danny Thomas or Loren Greene sell you some kind of product late at night, along with those movies, I just can't believe it.

I think there's enough risk out there in the world the insurance companies will continue to make great profits doing it. And I find that some of the insurance companies if you heard the testimony earlier today as a matter of fact, reluctantly but with about as much enthusiasm as the AFL-CIO, the company with almost half the business in the Medigap area have endorsed our bill.

I would suspect that reluctantly and with some revisions, at least the AARP is suggesting that the benefits, and I'm not sure they like our bill but they like the benefits, and then more, it's going to put them out of the medigap business, which they sell, and from which they get some revenues to operate their other good works.

So I'm not sure that these people who are most concerned and the insurance companies included won't support it. It's, I suspect only those who have the most egregious marketing policies and that might be somewhat reluctant.

But I hope that we can work together on this: the insurance companies and the private sector and labor, government. There's not much quarrel about what the benefits are. There's some quarrel about who ought to provide the benefits. And there's not much quarrel about the cost. And as a practical matter, the cost is being absorbed by society. Either your increased real estate taxes or your increase as a businessman, your increased premiums for medical insurance for your employees, or in labor, the increased costs to other benefits that you like to provide.

Somebody's paying for all this, because very few people don't get any care at all. All we're trying to do is readjust the burdens here, and perhaps in so doing, be a little more efficient, because we are basically non-voluntary, and everybody's in. And that was the magic of Medicare and Social Security and hopefully we can do that a little bit in I guess health security.

Did you want to have the last word?

Mr. GOLDBECK. It's your decision whether it's last or not.

A lot of the agenda of this committee, including this particular topic, is grappling with a fairly generic issue: social policy versus insurance policy. They are not necessarily the same. Those services which the values of the society, as reflected in law, have determined are to be achieved through social policy often cannot be achieved, or really do not fit, in a strictly market-oriented system. Because the ability to make the market work is often contrary to the social objective of access.

The catastrophic coverage issue is a classic example of that. Clearly, the private sector could provide coverage for anybody it wants to. It's always able to do that. There's never been a prescription that said the private carriers were not allowed to provide this coverage.

Private sector has responded in an eminently rational fashion. Economically, it has done precisely what made sense by good insurance standards. And that good insurance standard says the market eludes people. If you wish to bring these people under the so-called safety net you need social policy, not market insurance policy to accomplish that objective.

There are things that through the normal functions of markets and insurance can be accomplished infinitely better in the private sector than through a social policy prescription of government. But, once a group of the population has been determined to be most appropriate for the social umbrella, then you have to look at where normal market conditions become ineffective, and a social policy must fit the social objective.,

Chairman STARK. We'll get you back to argue that point often and loudly.

Thanks very much for all of your participation.

The subcommittee is adjourned.

[Whereupon, at 3:17 p.m., the subcommittee was adjourned.]

CATASTROPHIC COVERAGE UNDER MEDICARE

MONDAY, MARCH 30, 1987

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:05 a.m., in room 1100, Longworth House Office Building, Hon. Fortney H. (Pete) Stark (chairman of the subcommittee) presiding.

Chairman STARK. The Health Subcommittee of the Ways and Means Committee will begin its fifth hearing on including catastrophic coverage in the Medicare program. To date, we have heard from a variety of witnesses. Some have come before us to urge we expand Medicare beyond the Bowen or the Stark-Gradison proposals; others have stated that the private sector is already meeting the needs of the elderly or should be encouraged to fill the gaps left by Medicare.

I believe that the benefits contained in what is known as the Gradison-Stark proposals, H.R. 1280 and H.R. 1281, are the minimum hospital and physician benefits the subcommittee should consider.

Medicare can bring peace of mind to the elderly and disabled who will need hospital care by limiting liability to one hospital deductible. It will also take a great deal of the confusion out of the present Medicare benefits.

Medicare can also make predictable out-of-pocket costs for physician services by capping these expenses at \$1,000 for covered services and, indeed, making the beneficiaries aware of the possibility of using the services of participating physicians. This provisional loan would help an estimated 2.5 million older Americans.

Well, our proposed benefits are the minimum the subcommittee should consider, I believe. There are improvements in the Medicare program that can go beyond these benefits and, I think, ultimately should. The subcommittee must carefully consider any additional improvement that may be proposed. Every proposal must, of course, in the climate of today include a financing option, and this option has to relate to the medicare program.

Some have argued that the medigap insurance market already provides catastrophic coverage. This is, in part, true. However, no private insurance company can provide the same benefits as contained in H.R. 1280 and 1281 as inexpensively as the federal government. Equally important, our bill will limit out-of-pocket expenses for the 20 percent of the elderly who now cannot afford a medigap policy.

We have asked both the administration officials and the National Association of Insurance Commissioners here today to discuss State regulation of medical supplemental insurance, better known as medigap policies, and make recommendations for changes in Federal law.

Other witnesses will focus on issues relating to the expansion of the Medicare program to include outpatient prescription drugs and improved mental health and dental benefits.

We will mark up catastrophic legislation in the subcommittee the week of April 6 and hope that the full committee will consider our recommendations soon after the spring recess. The need to end this specter of financial ruin from high hospital and physician charges is long past due.

I look forward to working with everyone to produce the best bill possible to aid the elderly in meeting all of their medical expenses.

There have been suggestions that many of us on the committee would like to expand the minimum benefits in the bills before us. I would just suggest that, as chairman, I would be happy to expand the Medicare benefits in any amount, in any direction, in any kind that is generally felt necessary and that we could pay for.

At present, I know of no priority list of whether we ought to look at pharmaceuticals before we look at more long-term care, before we look at more dental care; and it is my hope that we will get some objective testimony today along those lines.

I would like to welcome our first witness this morning, Thomas R. Burke, who is Chief of Staff of the Department of Health and Human Services; he is accompanied by Mr. King, the chief actuary of HCFA, and Mr. Jos, professional affairs adviser of HCFA.

It is generally our thought that we will try and hold witnesses to 5 minutes and hope that the members will elicit additional information from them in their inquiry. However, because of the important nature of our first witness, Tom, we would like to ask you to summarize your statement, and expand on it or proceed with it in any manner that makes you comfortable. A summary would be helpful for the committee, and do not pay any attention to the lights. Welcome back.

STATEMENT OF THOMAS R. BURKE, CHIEF OF STAFF, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY ROLAND (GUY) KING, CHIEF ACTUARY, HEALTH CARE FINANCING ADMINISTRATION [HCFA], AND PHILIP M. JOS, PROFESSIONAL AFFAIRS ADVISER, HCFA

Mr. BURKE. Thank you. Good morning, Mr. Chairman. I am Tom Burke, Secretary Bowen's Chief of Staff. I will submit a formal statement for the record, and I will summarize my remarks.

Chairman STARK. Tom, one other thing. In our trade war with Japan, we have not been able to get these new good microphones, so you have to pull this real close and almost swallow the microphone for everybody to hear you. Okay?

Mr. BURKE. Is that better?

Chairman STARK. Better.

Mr. BURKE. I am pleased to discuss with you issues surrounding our proposal to provide protection under the Medicare program for

those elderly and disabled Americans who suffer from an acute care catastrophic illness. Dr. Bowen has asked that I convey his appreciation for the Subcommittee's efforts in furthering the President's catastrophic protection initiative.

We are pleased that the bill submitted by President Reagan has generated a groundswell of interest in making this basic change to Medicare. I think, thanks in no small measure to Secretary Bowen and President Reagan, the question now in Washington has shifted from "Will we have catastrophic legislation?" to "When?"

As we enter the markup days of the legislative process, I would like to reiterate some of the key features of the President's bill and to share our concerns about some aspects of the Stark-Gradison legislation.

The key features of the administration's bill are: First, the President's bill provides peace of mind. Beneficiaries will have the security of knowing that their total cost-sharing obligations cannot exceed \$2,000 in 1988 or its equivalent in future years. The premium is low, a modest monthly cost that is affordable to the vast majority of our elderly. We spread the burden of the cost equitably over all 31.5 million beneficiaries who elect part B coverage.

The President's plan is self-financed and is budget neutral. The premium will be recalculated annually by the Medicare actuaries. All of the costs of the benefit are considered when the premium is computed: the program payout after a beneficiary meets the \$2,000 cap, the cost of the restructured part A benefit, the administrative costs, and any lost income due to hold harmless protection.

The discipline of actuarially determined premiums and a separate accounting system within the part B trust fund will ensure that the new catastrophic benefit remains a pay-as-you-go program with no inter-generational shifts of income and no inter-generational shifts of costs.

Our approach is simple and direct. For many beneficiaries, to reiterate what the chairman just said, the current Medicare benefit package is difficult to understand. Our bill eliminates many confusing elements. The spell-of-illness concept is eliminated; the sliding hospital coinsurances are eliminated; the number of hospital deductibles is capped at two per year; and skilled nursing facility coinsurance is also eliminated. We place a maximum dollar amount on out-of-pocket expenses, regardless of whether they come from part A or part B services.

Before I turn to a discussion of the Stark-Gradison bill, I would like to mention another feature of the President's bill, the carry-over provision. We all know that expenses do not fit neatly into a calendar year. There are instances when someone is hospitalized in December, runs up large out-of-pocket costs, and then is threatened with additional heavy expenses in January.

The President wished to protect the elderly and the disabled against large out-of-pocket expenses that were due to the misfortunes of timing. But this added protection can be expensive. Preliminary estimates from our actuaries indicate that it could add as much as 35 percent in cost to the premium just to protect a select few.

Because there may be other approaches which provide this type of protection at a more reasonable cost, we would welcome your suggestions on this issue.

Let me now turn to our concerns over the Stark-Gradison bill. I believe that the President's bill and H.R. 1280 and 1281 are not far apart on a number of significant aspects of catastrophic coverage, such as the restructured benefit package. But in other areas, we do have significant concerns. Specifically, we have concerns about equity, financing and administration.

I would like to share our thinking on these issues because some features of the Stark-Gradison plan were considered and rejected by the Secretary when he prepared his report to the President.

First, let us talk about equity. The President's plan is financed by a low premium. This premium in 1988 would be approximately \$72 for the year. By 1990, under our plan, each beneficiary would pay \$90 a year, while the maximum contribution under Stark-Gradison would be \$603. We do not believe this is a fair way to finance catastrophic protection.

For considerably less than \$495 under the Stark-Gradison plan, a beneficiary could purchase catastrophic coverage in the private sector. Further, our premium is paid by each and every part B enrollee—31.5 million beneficiaries. In contrast, the Congressional Budget Office estimates that, under the Stark-Gradison proposal in 1988, 19.8 million beneficiaries would pay nothing for catastrophic coverage, 7.8 million would pay \$265 in additional taxes, and 2.4 million would pay \$495 in additional taxes.

Thus, one-third of the beneficiaries would foot the bill for everyone's coverage. We believe this is unfair and unnecessary. Unlike the President's proposal to create a self-financed insurance program, the Stark-Gradison bill imposes a new tax. The President has consistently voiced a strong opposition to new taxes.

The Stark-Gradison bill could bring a substantial number of the elderly back on to the income tax rolls, some of whom would have been exempt from filing a tax return due to the recently enacted tax reform legislation.

Now, about financing. Our bill creates a separate funding mechanism for catastrophic coverage within the part B trust fund. Premiums and expenditures for the catastrophic benefit will be actuarially monitored to ensure its self-financing nature. If our premium income does not cover expenditures, we would know it and adjustments would be made in subsequent premiums. We can guarantee that none of the costs of financing the catastrophic benefit will be borne by other generations.

In contrast, congressional estimates indicate that Stark-Gradison could add \$800 million to the fiscal year 1988 deficit. We believe that the Stark-Gradison bill guarantees revenue shortfalls. A proposal that taxes some portion of the value of the Medicare benefit package cannot guarantee a year-end match of revenues and expenditures. There is a built-in cost escalation due to the indexing methodology; there is no annual reconciliation required, and since the actuarial value of the Medicare benefit will increase over time, there is a built-in tax increase.

We also envision difficulty with the start——

Chairman STARK. Could I interrupt, Tom? Is it not true that while there is an \$800 million shortfall, in 1989 in our bill, there is a pickup of a billion and there is a \$700 million pickup in 1990; so that over a 3-year window, we are actually \$900 million to the good.

I am willing to accept the \$800 million as accurate in 1988, but I believe—and if you are not aware of that, your staff could look into it—we pick up a little over the 3 years.

Mr. BURKE. We will. We envision difficulties with administering the Stark-Gradison proposal. No changes are required to collect the catastrophic premium under the President's plan. Stark-Gradison will involve changes to the tax instructions and the provision of complex information to beneficiaries under a subsidized benefit amount. This is certain to cause confusion among our elderly beneficiaries and may result in compliance problems. In contrast, the combined part A and part B cap in the President's plan is simple for beneficiaries to understand.

In conclusion, let me say that I hope the members of this subcommittee and Congress will look long and hard at the implications of financing the catastrophic benefit based on the tax and the amount of the beneficiary's subsidized benefits. I believe the financing mechanism in the Administration's bill is simpler to understand, fairer to beneficiaries and more sound financially.

In the weeks to come, we hope to work with this subcommittee and other Members of Congress to craft a bill in accord with the President's policy. This will remove the fear of financial devastation due to an acute care catastrophic illness without further exacerbating the Federal deficit.

I have submitted with my testimony, an appendix addressing a number of the issues, including current implementation plans, estimates of start-up and ongoing costs, and current estimates of the catastrophic premium.

I will be happy to answer any questions you have at this time. Thank you.

[The prepared statement follows:]

STATEMENT OF

THOMAS R. BURKE,
CHIEF OF STAFF,
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good Morning, Mr. Chairman. I am Tom Burke, Secretary Bowen's Chief of Staff, and I am pleased to be here today to discuss issues surrounding our proposal to provide protection under the Medicare program for elderly and disabled Americans who suffer from an acute care, catastrophic illness.

The Secretary is pleased that the bill submitted by President Reagan has generated a groundswell of interest in making this basic change to Medicare. Dr. Bowen asked that I convey his appreciation for the efforts to date of the Subcommittee in furthering the President's catastrophic protection initiative.

As we enter into the mark-up phase of the legislative process, I would like to reiterate some of the key features of the Administration's bill and to share our concerns about some aspects of the Stark/Gradison legislation.

KEY FEATURES OF THE ADMINISTRATION'S BILL

The Administration's bill is simple and direct. It provides peace of mind to beneficiaries for a modest premium that is paid by all beneficiaries. Finally, it is structured to be budget neutral.

Now, let me briefly elaborate on each of these points.

Simple and Direct - For years, the Medicare benefit package has been close to incomprehensible for many of our beneficiaries --

hospital benefits were tied to spells of illness and the amount of cost-sharing varied depending on the day of the hospital stay. In our bill we propose to greatly simplify the Medicare benefit package. We eliminate hospital cost-sharing beyond two deductibles in a calendar year. We also move from a spell of illness concept with a limited hospital benefit to an unlimited acute care benefit for covered services. Catastrophic protection is provided and financed in a direct and understandable manner.

Peace of Mind for Beneficiaries - Under current law, Medicare requires the greatest cost-sharing from beneficiaries with the most serious health problems. Beneficiaries faced with serious acute illness have to worry not only about their recovery but also about how their illness will impact on their financial well being. Under the Administration's catastrophic bill, all this is changed. Beneficiaries will have peace of mind knowing that the total of their copayments and deductibles cannot exceed \$2,000 in 1988 or its equivalent in future years.

Low Premiums / Burden Shared Equally - Under the Administration's plan, the cost of the catastrophic benefit is shared by all 31 million beneficiaries. Beneficiaries will be able to purchase financial security from the devastating impact of acute catastrophic illness for a reasonable monthly premium. The price tag for an individual beneficiary, which I explain more fully in the appendix to my testimony, is low because all can benefit from the group's large size and the low administrative costs of the Medicare program.

Budget Neutral - If you examine the President's proposal, you will find that all of the costs of the catastrophic benefit -- the program payout after a beneficiary meets the cap, the cost of the restructured Part A benefit and all catastrophic-related administrative costs, and any lost income due to "hold harmless" protection that may limit an individual's future premium increase -- are considered when the premium for the catastrophic benefit is computed.

The premium needed to finance the catastrophic benefits will be annually recalculated by the Medicare actuaries. We are proposing to separately account for catastrophic expenditures and premiums by creating a separate accounting within the Part B trust fund. The discipline of actuarially-determined premiums and a separate accounting will ensure that the new catastrophic benefit remains self-financed and budget neutral.

Carryover Protection - As we all know, the expenses of a major illness frequently don't fall neatly into one calendar year. For example, an elderly beneficiary can be hospitalized in December and run up large out-of-pocket costs. Without some type of "carryover" protection, on January 1, large out-of-pocket expenses could again threaten that elderly family's income. The President proposed to better protect the elderly against arbitrary, but large, out-of-pocket costs simply due to unfortunate timing of an illness.

Precisely because such a provision protects Medicare beneficiaries more completely and fairly, it is costly. The Medicare actuaries are in the process of refining their cost estimates, but this protection to a select few could add as much as 35% to the premium for all beneficiaries.

Our specific carryover provision is just one of many ways to reduce the possible arbitrariness of an annual accounting period. There may well be other approaches which provide this type of protection at a more reasonable cost, and we would welcome your suggestions on this issue.

THE STARK/GRADISON LEGISLATION

The President's bill and H.R. 1280/1281 share some features, such as the restructured benefit package, and are not far apart on a number of significant aspects of catastrophic coverage. We do, however, have specific concerns about equity, budgetary impact and administration. I'd like to share our thinking on these issues because some features of the Stark/Gradison plan were considered and rejected by the Secretary when he prepared his report for the President.

Equity - The Administration's plan is financed by each and every Part B enrollee paying a modest premium. In contrast, CBO estimates that under the Stark/Gradison bill in 1988, 19.8 million beneficiaries would pay nothing for catastrophic protection, 7.8 million would pay \$265 in additional taxes and 2.4 million would pay \$495. Thus, one third of the beneficiaries would foot the bill for everyone's catastrophic protection. By 1990, the maximum contribution under Stark/Gradison will be \$603. We do not believe that this is fair.

New Tax - Unlike the President's proposal to create a self-financed insurance program, the Stark-Gradison bill falls short because it imposes a new tax and is not budget-neutral. The President has consistently voiced his opposition to new taxes.

Budget Impact - In contrast, in the Administration's bill, we're proposing to create a separate funding mechanism for catastrophic within the Part B trust fund. Premiums and expenditures for the catastrophic benefit will be actuarially monitored to insure its self-financing nature. If our premium income doesn't cover expenditures, we'll know it and actuarial adjustments will be made to subsequent premiums. If our plan is adopted, we can guarantee that none of the costs of financing the catastrophic benefit will be borne by other generations.

Congressional estimates of the Stark/Gradison bill indicate it would add \$800 million to the FY 1988 deficit. We believe that the Stark/Gradison bill guarantees a shortfall. The year-to-year match between income and expenditures cannot be guaranteed by proposals that tax some portion of the value of the benefit package. We have only to look to the Medicare Part A trust fund to appreciate the difficulties of matching dedicated taxes to program expenditures --and with Part A the funding source is certain, because it is a fixed percentage of payroll. Other aspects of Stark/Gradison, such as indexing the cap and the hospital deductible to the Social Security COLA rather than to program costs, will make it even

more difficult for revenues to match expenditures; this is especially so when no annual reconciliation is required.

Administration - The catastrophic premium under the Administration's plan will be added to the Part B premium. Since we already have an administrative mechanism in place for the collecting the premium, no changes are required to collect the catastrophic premium. Stark/Gradison will involve changes to tax instructions and providing information to beneficiaries on their subsidized benefit amounts. This is sure to cause confusion among our beneficiaries and result in compliance problems.

CONCLUSION

I hope the members of this Subcommittee and of Congress will look long and hard at the implications of financing the catastrophic benefit based on a tax on the amount of beneficiaries' subsidized benefits. I believe the financing mechanism in the Administration's bill is simpler to understand, fairer to beneficiaries and more sound financially.

In the weeks to come, we hope to work with this Subcommittee and the other members of Congress to craft a bill in accord with the President's policy. This will remove the fear of financial devastation due to an acute care catastrophic illness without further exacerbating the Federal budget deficit.

I have attached to this testimony an appendix which addresses a number of issues including: current implementation plans; estimates of start-up and on-going administrative costs; and current estimates of the catastrophic premium.

I'd be happy to answer any question that you may have in regard to issues raised in my testimony or in the appendix.

IMPLEMENTATION PLANS

To implement the catastrophic health insurance plan, we are exploring ways to consolidate Part A and Part B payment information for each beneficiary in order to more effectively provide medical review of Medicare services. Under such a system, a file would be established and maintained for each beneficiary containing both Part A and Part B payment information. We envisioned that these common working files would be located in a number of contractor sites across the country, with each site being responsible for beneficiaries residing in a certain geographic location.

As each claim is received, the intermediary or carrier processing the claim would send the relevant information to the common working file contractor responsible for that beneficiary's records. The contractor would examine the beneficiary's file to determine whether the catastrophic limit had been reached. If this were the case, the contractor could then tell the carrier or intermediary to pay the claim in full. Thus, we would have prepayment information about the amount of out of pocket expenditures of beneficiaries and we would be able to pay their bills in full once the cap amount was met.

Based on our preliminary analysis, this is the direction we believe we should go in tracking the catastrophic cap amount; however, we are not in a position to be able to fully implement the common working file approach by January 1, 1988.

We are currently beginning the demonstration of such technology in two sites. Therefore, we are considering an interim measure to serve as a bridge until we are ready to fully implement the common working file technology.

Under this approach, we would use the existing flows of bill information from the contractors, called the Part A UNIBILL and

Part B payment record to determine whether a beneficiary has met the cap. These records are currently processed centrally by HCFA and would continue to be done this way. HCFA would then sort the combined files by beneficiary and send this information out to a contractor who would update the beneficiary's file and determine whether the cap had been met. Individual contractors would be able to query the common working file sites to ascertain if a beneficiary had reached the cap.

This interim system can be ready by January 1, 1988. The major difference between what we will be able to do for next year and where we hope to be in 1989 or early 1990 is how soon we will be able to know whether a beneficiary has met the cap. Eventually, we will know on a prepayment basis when a beneficiary meets the cap. Next year, however, due to the delay in posting bills to the beneficiary files, there will be a delay of up to 30 - 45 days after a bill is received by the contractor before we will know the beneficiary's status. This is not a bad interim step.

ADMINISTRATIVE COSTS OF CATASTROPHIC INSURANCE

We have developed estimates of how much it will cost to implement the catastrophic benefit if the Administration's bill were enacted. It is our intention that the catastrophic benefit be implemented in a budget neutral manner. All administrative costs incurred to implement and run the program should be financed through the beneficiary premium.

To begin implementation, we estimate that approximately \$40 to \$60 million will be required for our contractors, systems, development and other activities. We include start-up costs of about ten cents per month in the first-year premium. In addition, on-going administrative costs of about five cents per month would be added to the first and all future years' premiums.

CURRENT ESTIMATES OF THE CATASTROPHIC PREMIUM

Since, I have broached the subject of the premium, let me now

address it directly. When Dr. Bowen first proposed the catastrophic benefit, he estimated that the monthly premium would be approximately \$4.92. That estimate assumed implementation in 1987 with a \$2000 cap.

Recently, I asked HCFA's actuaries to recompute the cost of the premium for our original proposal. According to their calculations, it would cost about six dollars without the carryover provision, and the carryover provision could add up to two dollars per month more. The increase is not indicative of the type of annual growth that we anticipate in the premium if Administration's bill were enacted. The magnitude of the increase is directly related to the fact that the Administration's proposal still contains a \$2000 cap and because we have added the important, new carryover protection not originally considered when the \$4.92 provision was calculated. Because of the increase in costs between 1987 and 1988, 150,000 additional beneficiaries will become eligible for the catastrophic benefit because the cap was not increased by program growth.

As you are aware, the cap in the Administration's proposal is indexed to program growth, so in future years we anticipate that the growth in the premium will be close to the growth in per capita benefits. We do have out-year estimates for the premium. For Secretary Bowen's original proposal the premium would increase by about ten percent in 1989.

Chairman STARK. Tom, thank you. I think you make a fair assessment of the differences. Let me just run through them.

Your proposal, unless I am missing something, for the first time puts a premium, a voluntary premium, on a part A benefit, which up until now has been a nonvoluntary entitlement. Is that not correct?

Mr. BURKE. No. It is a part B premium.

Chairman STARK. I know it, but that is a voluntary premium.

Mr. BURKE. To the extent that part B is voluntary.

Chairman STARK. Okay. And it is not an entitlement, three-fourths general revenues, and it goes to fund basically an increase in part A benefits.

Mr. BURKE. To some extent. Most of the benefit will go to part B.

Chairman STARK. I know it, because there are a lot of people to whom this is important, for several reasons, congressional jurisdiction not the least of them.

Mr. BURKE. Yes, I am aware of that.

Chairman STARK. People who believe that Medicare and Social Security should never be welfare; therefore, it has to be an entitlement with no entry limitations at all and no voluntarism. I have been accused of putting my head under the tent a whole lot of times, but I do not think I am being incorrect. I may be picking at minuscule items here, but I just want to make sure we are both agreeing.

The premium that you are suggesting would, in fact, be voluntary and it would, in fact, fund some part of what we know as part A benefits.

Mr. BURKE. Right.

Chairman STARK. Okay. And that is a concern. I did not know if you were aware of that.

Mr. BURKE. Yes.

Chairman STARK. As it was structured. Had you thought of any alternatives that would get us over that unknowing detail?

Mr. BURKE. The amount of money from the premium that will go to fund part A is very small. Virtually all of the premium goes to part B expenses and the administration of the \$2,000 cap.

Chairman STARK. In our bill, however, it is 40 percent. Our part A benefits are far more generous.

Mr. BURKE. You have eliminated one of the two deductibles. Correct.

Chairman STARK. Under your proposal, the poor and near-poor, people who are under 200 percent of the poverty level, under about \$10,000, are going to end up paying a third of the premiums.

Mr. BURKE. Will end up paying what?

Chairman STARK. One-third of the premiums will be paid by people in poverty or near poverty, under two times the poverty level. Does it concern you that some of those people—and they make up about half our Medicare beneficiaries—will have to drop out of the program or will not be able to afford it? What do we do about them?

The marginal extra money under your program for the very poor may disqualify them. What do we do about those folks?

Mr. BURKE. The very poor are currently handled through dual eligibility in Medicaid.

Chairman STARK. No, let us say they are not on Medicaid. They are just poor.

Mr. BURKE. We think our premium is sufficiently low that it is affordable.

Chairman STARK. Okay.

Mr. BURKE. You are always going to have a notch.

Chairman STARK. All right. So you are willing to accept that as an alternative?

Mr. BURKE. Yes.

Chairman STARK. You do not think that it is fair to ask high income individuals to pay more for whatever extra benefits they receive? But, in fact, they do throughout their working career—we cap it, however—pay a bigger tax and end up with the same Medicare benefits as the low income workers. And I do not know what the administration's position was when we taxed Social Security benefits. I do not know that anybody liked it, but we had to do it.

I do not know whether the President went along with that or not. I think he accepted that.

So I wonder what is different about our proposal to spread the cost in a more progressive manner? Even though the amounts under your bill may be small, what is the objection to making this payment higher? And we can, I might add, so please do not say it is a tax, because we have found out that with equal ease of administration, we could just construct an income tax-related fee. This answers your question of putting about 1½ million new people on the rolls. We would call it a premium. We just collect it through the tax bill so if you do not file, you do not pay. We would pick up the same dollars, by calling it a fee.

This is an alternative which is available to us. It does away with the tax issue and makes it more or less an income-related premium.

So taking those two, what is the objection to making income-related or a progressive way of paying for this program?

Mr. BURKE. I do not want to rule that out; it has not been fully considered, and is not off the table.

I do think, however, that catastrophic legislation is not the vehicle to inject means testing into the Medicare program.

Chairman STARK. Could I stop you there a minute?

Mr. BURKE. Yes.

Chairman STARK. Only because it is very important definitionally. Means testing in our semantic world has always applied to access. SSI is means tested. You have got to be poor enough—

Mr. BURKE. On income-related premiums.

Chairman STARK. Yes, okay. Because really a lot of people, including myself, do not like means testing.

Mr. BURKE. All right. It has a bad name.

But this is not the vehicle. A catastrophic benefit is not the vehicle, it seems to me, to interpose this. If you are going to do it, there are other better ways to do it and face up to the issue.

Chairman STARK. Okay. Well, as I say, the Social Security tax is now income-related, so I do not quite know.

But let me ask you a final question, if I may. Before that, by the way, I thank you. I do not know whether this is a great favor or not, but I know you canceled a speech in Chicago today so you

could be here with us. I appreciate it. I know the Committee does, too. I appreciate your adjusting your schedule to ours.

Mr. BURKE. It was Florida.

Chairman STARK. Florida. That is even double thanks. Well, it is raining in Florida. It is not raining here yet.

Not limited to these, but if you had your wish list from your bill's benefits or our bill's benefits, and if our Great Aunt Budget died tomorrow and left us a couple of billion dollars a year to spend, without any commitment to size, would you move your benefits up to our level; in other words, do away with the second co-pay and keep the total out-of-pocket a little lower in the areas that we are both covering? Would you move to pharmaceuticals, to more long-term cares, more skilled nursing, dental care?

What areas would you add, if we could, and in what order if you have any order in mind?

Mr. BURKE. I would not be inclined to do so, if we are talking in terms of a catastrophic benefits. If we are talking in terms of a benefit that should by definition hit two tails of a distribution, all right. If we lowered the cap consistent with yours, more people would hit it, and hit it faster, and you would have a part B escalation effect.

I think, if one looks at the benefit package, it could be argued that there is room for some enhancement. I am answering your question in the context of "if I had a windfall of several billion dollars."

Chairman STARK. Absolutely.

Mr. BURKE. I would like to think, though, that right now we are looking at a situation where we have more ways than means. My first inclination would be to get things leveled off before we start thinking about the enrichment of the benefit package.

Chairman STARK. I understand that. It is an issue that we are hearing here. Cannot we establish at least a way we would go? I think we can. The question is, which benefits seem to be most catastrophic in nature? Which would give the most relief to the most people if, in fact, we found this windfall, if our means began to exceed our ways?

Mr. BURKE. Possibly pharmaceuticals, that is an area where a dual cap, for example, might be considered at some time when our ways and means are in better equilibrium.

Chairman STARK. Thanks very much.

Bill.

Mr. GRADISON. Thank you, Mr. Chairman.

Mr. Burke, after listening to your testimony, I am confused why you do not prefer our method of separating A and B, rather than combining them. It sounds to me as if you are going to have to totally reorganize a system over a considerable period of time in order to have a benefit that combined A and B; and that if you separated them, as we have suggested, it would just be a whale of a lot easier. It may not be as fair, but it might be a lot easier to administer.

Could you comment on that, please?

Mr. BURKE. I believe that the approach we are taking toward combining A and B is the direction in which HCFA was headed before the catastrophic proposal even surfaced. It is a better man-

agement tool. You look at the cost of an illness, and you see what is happening to the cost of an illness.

Keeping B separate from A is, I think, artificial. If a person goes into the hospital, the expenses he or she incurs are connected with that hospitalization. And it makes sense to us to put them all together.

Also treating part B separately, you are perhaps overlooking a large chunk of what could be the out-of-pocket expenses.

Mr. GRADISON. I have a question for Mr. King.

Mr. King, I would be interested in knowing what your recommendation was to the Secretary with regard to the update for PPS hospitals for fiscal year 1988?

Mr. KING. I did not make a recommendation to the Secretary this year, sir.

Mr. GRADISON. Who did make recommendations? Who did the actuarial work, Mr. Burke, that has led to the ranges that are being considered? I am not talking about the original budget, the placeholder; I am talking about the figures that are working. Who is working on that?

Mr. BURKE. HCFA is working on it. I have been involved in it to some extent. I do not think it is purely an actuarial drill. I think the actuary has given us data, but this is being tempered with some economic analysis that is being done in the Office of the Assistant Secretary for Planning and Evaluation and elsewhere in HCFA. The recommendation that will be coming forth from the Secretary will certainly utilize the data that has been given to us by the actuary, but it will utilize a lot of economic analysis that has gone into the exercise also.

Mr. GRADISON. Did the actuarial data suggest a range, if not a specific number?

Mr. BURKE. I don't recall if I looked specifically at the actuarial data; I do not remember exactly.

Mr. GRADISON. Let me ask Mr. King that question. Did your actuarial data that you have submitted for 1988 for the update include a range of reasonable numbers, if not a single number?

Mr. KING. Yes, it did, sir.

Mr. GRADISON. Could you tell us what that range was, please?

Mr. KING. I basically told our Deputy Administrator, who is the primary policymaker involved in working with the update factor this year, that the upper end of the range that we came up with roughly corresponded to the bottom end of the range he was considering.

Mr. GRADISON. Could you give us numbers? I do not know what you are talking about. What numbers were in the ranges? You suggested a range. What were the numbers?

Mr. KING. Well, zero was the upper end of my recommended range.

Mr. GRADISON. So the maximum update that you recommended is zero? Is that correct?

Mr. KING. Yes, sir.

Mr. GRADISON. Okay. Thank you very much, Mr. Chairman.

Chairman STARK. Mr. Coyne?

Mr. COYNE. Thank you, Mr. Chairman.

Mr. Burke, do you anticipate that the catastrophic provision we are discussing here today is going to be on a voluntary basis? Is that your proposal, to make it catastrophic or voluntary?

Mr. BURKE. Our proposal is voluntary as is the part B benefit. But as you know, some 97 percent of the people who now have part A voluntarily elect part B, because it is the best buy in town; 75 percent of the revenues are out of the Treasury, only 25 percent comes out of their own pockets.

We would add to the part B premium a fully financed add-on. Now, those who do not take part B are, by and large, people who live outside the United States, live near military installations and receive their prescriptions and outpatient care in those types of facilities.

Mr. COYNE. Would you anticipate that there would be any increase for those who would not participate in part B.

Mr. BURKE. We do not anticipate it would be a change in the participation rate for part B, no.

Mr. COYNE. On that basis, I wonder if you could explain a little bit further the breakdown of the categories that you have here, the 19.8 million who would have premiums of zero. What level of income does your chart indicate that that is?

Mr. BURKE. The chairman perhaps could better speak to that.

Mr. COYNE. Well, I thought inasmuch as you had the breakdown there, you might be able to explain it.

Mr. BURKE. I believe that starts at an income level for single returns of \$15,000; for joint returns, \$22,500.

Mr. COYNE. So how does that relate to the chart, the \$19.8 million?

Mr. BURKE. Anyone with income of that or lower would pay nothing.

Mr. COYNE. So what we are addressing is the poorest people who would be able to participate?

Mr. BURKE. Yes.

Mr. COYNE. And above that, right above that, the \$7.8 million would be \$265.

Mr. BURKE. Correct. Now, I should add that I am in receipt of a letter from the American Association of Retired Persons which points out that, if the Stark-Gradison proposal becomes law, 2 million additional elderly beneficiaries would pay taxes who would not have without Stark-Gradison.

Mr. COYNE. Could you explain further how that happens?

Mr. BURKE. Well, the net effect of the Stark-Gradison proposal is to add the actuarial value to beneficiaries' incomes. Their incomes will rise, therefore, and they will be subject to additional taxes.

Mr. COYNE. But it appears from the chart that the poorest of the poorest of the population would be paying nothing.

Mr. BURKE. Correct.

Mr. COYNE. In any event.

Mr. BURKE. Correct.

Mr. COYNE. Thank you.

Chairman STARK. I am going to ask if Mr. Anthony would indulge me for one question right on that point.

Under either plan, the Bowen proposal, or Mr. Gradison's and mine, there would be a savings to Medicaid.

It is our feeling that we might like to mandate the States to take that savings and, starting at the bottom of the income scale with the very poorest, buy in their Medicare coverage.

Would you agree to that proposal regardless of who wins? Do you want to cut a deal with me today?

Mr. BURKE. It does not bother me.

Chairman STARK. Our savings would be a little more; yours would be a little less. But our feeling is to let us take that savings and have Medicaid buy in for the very poorest, which would take some—I hate to give you spots of these points because you are so far ahead of us here—but that would take some of the very poorest off under your proposal.

Mr. BURKE. The savings to Medicare under our proposal, it could be argued, would be significant, if you accept the premise some research studies have pointed out that the poor elderly tend to be the sicker elderly who have not received their high blood pressure medication and so forth. Therefore, they would incur higher medical expenses; the impact of the administration's proposal would be very advantageous to the State Medicaid programs.

Chairman STARK. I am sorry, Mr. Anthony.

Mr. ANTHONY. Thank you, Mr. Chairman.

In your deliberation with the catastrophic package that you sent to the Congress, you obviously had some internal debate before you arrived at the \$72 premium. Some probably wanted it higher, some wanted it lower.

Was there any debate internally in trying to expand the coverage past where you finally settled; that is, to do anything with part of the long-term care or to do anything with outpatient drugs?

Mr. BURKE. If you will look at the report that the Secretary submitted to the President, there is quite a lengthy section on long-term care that, unfortunately, has not been debated as extensively as the Medicare expansion.

We studied a private sector approach to long-term care. We think there is a lot that can be done in the private sector if changes are made that allow them a level playing field, such as eliminating DEFRA barriers for long-term care insurance. Long-term care insurance is an infant industry which is expanding rapidly.

Another option that the Secretary proposed was an individual medical account that provides a mechanism for citizens in middle America to go out and take advantage of tax-sheltered earnings to provide for their health needs in later years—I think this is an innovative approach, which does not rely totally on the public sector.

So we did look at long-term care, but we did not look at long-term care in the sense of infusing more Federal money. The rationale was that this is not the time. If you look ahead you will find that to provide a long-term care benefit in 1987 dollars, by the year 2020 you are looking at an outlay of about \$100 billion. Right now, we are faced with a \$160 billion deficit. This did not seem to be a good time to propose an expansion into the long-term care area. It would be very expensive.

Mr. ANTHONY. What about the outpatient drugs issue?

Mr. BURKE. We did not propose an expansion of currently covered benefits. This was not the proper time, given the size of the deficit, to be proposing program expansions.

Mr. ANTHONY. If you have a pay-as-you-go program, what difference does it make what the size of the deficit is?

Mr. BURKE. If you want to talk about drugs, we did look at drugs, and we looked at drugs extensively. There is no good data base on drugs. The only State that has a reasonably good set of data on drugs is Pennsylvania. We examined Pennsylvania's system. We found that there is a distribution system for drugs which may make it susceptible. But we would be taking a Herculean leap to put drugs into our proposal without better data on which to assess what the dollar impact would be. We would not be able to calculate the premium accurately.

There is no national data base on drugs. We have Medicaid drug utilization statistics in Pennsylvania that provide us with some good data. We looked at it. We did not think we were there yet, so we did not tackle it.

Mr. ANTHONY. If the administration sought to put a data base together to advise the Congress in the future, how long do you think it would take before an adequate data base could be put in place, just the mechanics of gathering the data?

Mr. BURKE. I do not think it would be quick. You are looking at possibly next year, I would think.

Mr. ANTHONY. Next year? And how many years of data collection would you want to have before you would make a recommendation?

Mr. BURKE. I would certainly want 1 year.

Mr. ANTHONY. So in the area of drugs, you think we would probably be at least 2 years out before the administration—

Mr. BURKE. I think before you can intelligently tackle that problem, yes.

Mr. ANTHONY. Sir?

Mr. BURKE. I think before you can intelligently tackle that problem and look at the drug issue and what it would cost, you are looking at a couple years down the line.

I do have some data that shows, though, that 68 percent of the drug expenses of the elderly were paid out of pocket, though the distribution was uneven; about 6.3 percent of the elderly reported they incurred about 55 percent of the total out-of-pocket prescription drug costs, and less than 1 percent—1 percent—accounted for over 15 percent of the total out-of-pocket expenditures. So it is susceptible to catastrophic coverage. But we would need to get a better fix on it.

Mr. ANTHONY. If we could just get a better fix.

Mr. BURKE. Yes.

Mr. ANTHONY. So in your opinion, it is just a matter of drawing the data together so we could make some rational decisions.

Mr. BURKE. And make a reasonably good estimate of what the premium would cost.

Mr. ANTHONY. What the premium would be. Thank you very much.

Chairman STARK. Mr. Chandler.

Mr. CHANDLER. Thank you, Mr. Chairman.

I know that I cannot get an answer to this question at the hearing today, and I have submitted it to Mr. Burke, but I would like to read it into the record so that we have note that it was asked.

Mr. Burke, I understand the President's Medicare catastrophic proposal is designed to be budget-neutral, and the Stark-Gradison plan has sufficient financing, at least in the near term, to fund its benefit enhancement.

I am, however, concerned about the implications of these catastrophic proposals for the fiscal integrity of the Medicare trust funds. The Congress has been reticent to sustain beneficiary sharing in the cost of the Medicare program in the past. So as Medicare catastrophic increases the cost of the Medicare program, despite the best intentions behind the current legislation's financing, the current drive for benefit enhancement may exacerbate the fiscal problems we face in the next decade and beyond in Medicare.

I would appreciate your supplying the subcommittee with projections within the range of optimistic and pessimistic on the marginal effect of the two catastrophic proposals on the cost of the Medicare program over the next 15 to 25 years. I understand that the department's actuaries can make these estimates, that they will have to do so for the Social Security Trustees report anyway, and that the projections will only take a matter of days to make.

Mr. BURKE. Could I comment on that, sir?

Mr. CHANDLER. Sure.

Mr. BURKE. As a point of fact, they do not project out the part B trust fund 15 and 25 years. That could not be done in a matter of months to do the part B projections that far out. It is not routinely done. It would require a program be established to do it, but we will look into it.

Mr. CHANDLER. Okay. How many individuals, again, would be covered by the Bowen plan?

Mr. BURKE. 31.5 million.

Mr. CHANDLER. Okay. One factor that I think is important to establish—and, Mr. Chairman, I do not recall anybody creating this number for the record—how many of those individuals would already have employer-provided health insurance that would essentially cover the same benefit to be provided, either by Bowen or Stark-Gradison?

Mr. BURKE. We have about 3.9 million individuals.

Mr. CHANDLER. That are currently under Medicare and participating in part B?

Mr. BURKE. Maybe, I misunderstood your question. I thought you said medigap; how many are provided medigap coverage by their employers?

Mr. CHANDLER. Right.

Mr. BURKE. I think it is about 30 percent of the Medicare beneficiaries; 13 percent are paid for by Medicaid.

Mr. CHANDLER. Is it a fair conclusion to draw that those individuals will find themselves without any greater benefit than they are already provided by their employer, and yet a new premium to pay with either Stark-Gradison or the Bowen plan?

Mr. BURKE. It would probably vary by employer. The employer may opt to pay this and select other medigap coverages. The medi-

gap coverage, I would think, since it is basically State run, the medigap laws would have to be changed to reflect any kind of catastrophic coverage that were enacted.

Mr. CHANDLER. Yes, but back to the original intent of the question: Would most of these individuals find themselves without any additional benefit but a premium for that benefit which is now paid by their employer?

I know that there are options that the employer could exercise.

Mr. BURKE. I guess other things being equal, yes.

Mr. CHANDLER. Thank you.

Chairman STARK. Mr. Daub.

Mr. DAUB. Thank you, Mr. Chairman.

How did the department arrive, Tom, at the \$2,000 threshold figure?

Mr. BURKE. The \$2,000 figure was arrived at because it is the inflation adjusted stop-loss equivalent of what is currently provided in employer-based plans.

Mr. DAUB. So in other words, we took a look at the private sector's insurance market and decided that the Government could do just as well and do it cheaper. So we will take their level, and we say we will provide it as a government and charge everybody \$4.92?

Mr. BURKE. With a cap, yes.

Mr. DAUB. Again, I will follow on Mr. Gradison's comments a little bit to make it perfectly clear the extent to which the \$4.92 premium add-on is going to finance the President's catastrophic acute proposal. Does that \$4.92 or the CBO estimate, which is \$6.40, finance 100 percent of the catastrophic expansion, or does it follow along our current part B 75—

Mr. BURKE. Let me take that in two parts.

The \$4.92 was the insurance component. It did not include administrative costs or start-up costs. It also does not include a cost that was added to the bill through the carryover provision. The funding, however, would be 100 percent from the beneficiary, not 75 percent from general revenues. In the year 1988, which would be next year, the \$4.92 would go up in the vicinity of 16 to 18 percent. We have a number of \$5.83. Part of that 16 to 18 percent—close to 9 percent of that increase, is due to the fact that, if the truth were known, we forgot to index the cap in 1988.

Mr. DAUB. All right.

Mr. BURKE. If the cap were indexed in 1988, it would drop down to around \$5.55.

Mr. DAUB. Now the truth is known.

Mr. BURKE. Now the truth is known.

If you index the cap in 1988—

Mr. DAUB. \$5.83?

Mr. BURKE. In 1988 that premium would fall. And we have the premiums projected with and without the administrative costs. The premium with administrative costs in 1988 is \$5.98.

Now, I should add that that figure includes first year start-up costs.

Mr. DAUB. Are we going to charge the beneficiary for that or not?

Mr. BURKE. Yes.

Mr. DAUB. So, then, the true costs are higher with the re-examination of all the factors, and careful study—we do that, too, you know. We take a look at something and then we look at it again and we refine our estimates. So we ought to be talking now about the Dr. Bowen——

Mr. BURKE. In 1988.

Mr. DAUB. In 1988. And that would be the first year, if everything would work as you indicated earlier, that it is not a question of if, it is a question of when.

Mr. BURKE. And I should add that the administrative costs in the first year are 15 cents. However, 10 cents of that 15 cents drops off in subsequent years because there is only a one-time start-up cost.

Mr. DAUB. Sure.

Mr. BURKE. So the ongoing administrative costs are 5 cents per month per beneficiary.

Mr. DAUB. Okay. Now, what is your 1989 projection, then, based on \$5.98?

Mr. BURKE. In 1989, we are looking at \$6.42 premium with a \$2,130 cap.

Mr. DAUB. With a \$2,130 cap?

Mr. BURKE. And with the administrative cost, it is \$6.47.

Mr. DAUB. \$6.47. What is the 1990 figure?

Mr. BURKE. 1990, it is \$17.17 with a \$2,280 cap with administrative costs——

Mr. DAUB. The monthly premium for 1990.

Mr. BURKE. 1990. \$7.17.

Mr. DAUB. There we go. The decimal slipped a little bit. You said 17, and I wanted to be sure that you meant 7.

Now, what is 1991?

Mr. BURKE. \$7.92.

Mr. DAUB. And 1992?

Mr. BURKE. \$8.92.

Mr. DAUB. Now, it would seem——

Mr. BURKE. The cap goes up to \$2,460 and to \$2,660.

Mr. DAUB. To \$2,660?

Mr. BURKE. Right.

Mr. DAUB. Would CBO agree with these figures now, do you think? Are you all in agreement yet, do you know?

Mr. BURKE. We believe that we are within 2 cents of CBO figures. According to our meeting last week, they had an assumed increase in utilization of 20 percent; we have a 10 percent. When you adjust their original estimates, they included administrative costs; ours did not. When you compare oranges and oranges, we are within a few cents variation.

Mr. DAUB. As we add approximately 1 million beneficiaries to the over-65 ranks and factor, then, approximately 95 or 98 percent of them may take the part B—and I assume you have all worked out this problem of how the part B voluntary premium can be handled in terms of paying for part A.

Mr. BURKE. Yes, we have.

Mr. DAUB. You have got that figure.

Mr. BURKE. It is in the appendix to the testimony.

Mr. DAUB. I appreciate that. I have got to study that a little bit. I do not know how to ask any questions about it yet.

You will be in a position where the program's total cost, then, would be how much over a 5-year period? Assuming the increase of about 5 million people by 1992 that will be eligible to take the program, what will the total cost be for the administration's plan?

Mr. BURKE. When you say the total cost?

Mr. DAUB. Is it going to be \$25, \$28, \$30 billion?

Mr. BURKE. I have the numbers. I do not have them summed over 5 years.

Mr. DAUB. Do either one of the other folks with you have that?

Mr. BURKE. No. We would have to take each year. I have got it for 3 years.

Mr. DAUB. Okay. What is your 3-year cost?

Mr. BURKE. \$2.3 billion, \$2.5 billion, \$2.9 billion.

Mr. DAUB. \$2.3, \$2.5, and \$2.9.

Mr. BURKE. As compared to \$4.1, \$4.7, \$5.7 billion for Stark-Gradison.

Mr. DAUB. Okay. My last question: Does the administration feel strongly enough about the tax in Stark-Gradison that at this point in time, if that were the final bill, they would have to oppose it?

Mr. BURKE. I am not in a position to answer that, Congressman.

Mr. DAUB. Thank you, Mr. Chairman.

Mr. BURKE. I think the President is rock solid against tax increases, though.

Chairman STARK. Mr. Levin.

Mr. DAUB. Just an innocent question.

Mr. LEVIN. Well, in view of that innocent question and the answer, let me pursue it. I would have, even if you had given a distinct answer. I am glad you did not give a definitive answer, though.

You said earlier that this is not the time to income-relate. Why not?

Mr. BURKE. No, I did not say that, Congressman. I said this is not the place to income-relate. I think there are two schools of thought on this issue. One school of thought would say there are poor people who would have their premium paid for them under Stark-Gradison, whereas they would have to pay the premium under the President's plan. But there are other ways of income-relating.

I understand Blue Cross and Blue Shield testified that you could income-relate the cap and that would produce additional dollars that could be used to reduce the premium.

If you are going to income relate, face the issue and do it. But why do it on the catastrophic portion of the Medicare program?

Mr. LEVIN. Why not?

Mr. BURKE. Why not do it on the whole program?

Mr. LEVIN. So you would favor doing it for the whole program?

Mr. BURKE. No, I asked a question, Congressman. I would defer to Congress on that.

Mr. LEVIN. But now I am asking you.

Mr. BURKE. I would think that the catastrophic bill is not the place to begin income relating the program and there are others——

Mr. LEVIN. Because?

Mr. BURKE. Others who would argue that it is unfair to. There are two schools of thought, as I said. One says you could pay the

lower income people's premium through this vehicle. Others would say it is unfair to tax the benefits of those who have acted prudently, judiciously, who have saved their money during their working years and are now in their older years, since in fact, you do not have a tax on employer-based health insurance benefits.

I am not saying I favor either one, but I think that there are other places that you could address income-relating. This is not the proper place. It is a small portion of the Medicare program.

Mr. LEVIN. Is it not true that we are going to have to do some income-relating as you look into the future?

Mr. BURKE. Probably.

Mr. LEVIN. So probably, I take it, really means yes.

Mr. DAUB. Would the gentleman yield?

Mr. LEVIN. Yes.

Mr. DAUB. What if we were trying here to raise the deductible or the copayment which would affect every beneficiary. For instance, the President's plan is designed to affect every beneficiary by charging him another \$4.92? But a million or so is about all the ultimate benefit will go to out of the 30-plus million people.

I mean, one approach gets a scream from Congress, and yet it seems like if we just raise the price for everybody, the way we are trying to now, we are not going to get a scream from everybody.

Mr. LEVIN. Well, I am not sure that you are not. The position of the administration seems to be that income-relating is around the corner but put off the day. Frankly, I do not understand that. That seems to be one of your positions.

The second position is that Stark-Gradison is not fair. You say on page 5 by 1990 the maximum contribution under Stark-Gradison would be \$603, and 7.8 million would pay \$265, 2.4 million would pay \$495, and 19 million would pay nothing. Somehow that is not fair, but it is fair for everybody except those who are most impoverished to pay the same.

I do not understand that.

Mr. BURKE. I did not say that, Congressman. I said that if you are going to income-relate the premiums, there is a whole menu of ways to do it.

Mr. LEVIN. Give us the menu instead of just saying you do not want to.

Mr. BURKE. I just gave you one. You have had Blue Cross and Blue Shield testify you could income-relate the cap.

Mr. LEVIN. No, but what you are doing, in effect, is not giving us the menu at all.

Mr. BURKE. Because we are not proposing it in the administration's bill.

Mr. LEVIN. Right. I do not understand that. You are saying look at the menu, but we are not going to present any alternative within the menu.

Mr. BURKE. We rejected income-relating premiums in our proposal.

Mr. LEVIN. Why?

Mr. BURKE. Because we think there are large social and economic implications to doing that which require a great deal of deliberation. We think that this is not the place. The catastrophic benefit, which is a small portion of the Medicare program with a modest

premium, is not the place to introduce a feature which could have a domino-like effect.

Mr. LEVIN. Domino. Is that bad or good?

Mr. BURKE. I do not know whether it is bad or good, Congressman. We just did not do it.

Mr. LEVIN. All right. A third position seems to be that there is opposition to new taxes. So I guess your position is that \$7 a month is not a tax. That is what it would be eventually, while if you somehow build it into the tax structure more directly it is a tax.

What is \$7? Is that a user fee, not a tax?

Mr. BURKE. No, that is not a user fee, Congressman, and it is not \$7 a month for a couple of years to come.

It is taking a pool that is very large and it is telling America's elderly, "You can spread your risk over 31.5 million beneficiaries and receive coverage a lot cheaper than you can buy it in the private sector". You are taking advantage of this risk pool, and you are providing insurance that does not have any medical restraints. It is accessible to everyone, and it is a good bargain.

We are basically using a marginal cost approach to Medicare to provide a very good catastrophic benefit to America's elderly at a very reasonable cost. That was the purpose of the plan. The purpose of the plan was not to introduce income-relating. It seems that the tax system is the place to address this, not a program which is an insurance program for the elderly.

Mr. LEVIN. It is not a user's fee?

Mr. BURKE. No, it is an insurance premium.

Mr. LEVIN. No further questions, Mr. Chairman.

Chairman STARK. Tom, let me ask you this. You are talking about having everybody pay, but in the difference between the two benefits, the \$1,500 to \$2,000, it is our understanding that only 2 million people will pay that extra \$500. But you could provide it under your proposal by having, in effect, 31 million people pay about \$6 more.

Why is that not more? Why should we not increase your premium a little, by your own rationale, and not rely on that small number of people to pay the \$500, which is 40-odd dollars a month?

Why should we stretch as far as we can to get? Every dollar of our benefits is coming out of a very small number of people at \$40 or \$50 a month. If I can replace that under the insurance principle at \$5 or \$6, why is not that better?

Mr. BURKE. I am not sure I understand your question.

Chairman STARK. Okay. The difference in our benefits plan, the Bowen versus Stark-Gradison—

Mr. BURKE. You have a \$1,000 cap on part B related expenses.

Chairman STARK. Well, \$500. Ours is \$1,500. Let us say you get really sick and spend a lot.

Mr. BURKE. All right. \$1,500. You have got—

Chairman STARK. Ours is \$1,500, yours is \$2,000.

Mr. BURKE. You have one deductible. We have two.

Chairman STARK. We estimate that the distribution will be such that only about 2 million people will pay the extra \$500. Okay? And you could increase your benefits under your proposal to our \$1,500 limit for about \$6 a month. Do you see what I am getting at?

So all 31 million beneficiaries would pay, in effect, \$72 a year rather than just 2 million getting hit with an extra \$500 a year. Now, you can bounce that around any way you want. So my question is, why is it not beneficial for us to get those benefits up as high as we can?

I am assuming for a minute that we got to a monthly premium—like you are saying—by raising that premium. Why would not that be desirable?

Mr. BURKE. I guess my question is I do not think \$500 is catastrophic. You know, you are talking about a group of America's population which asset-wise is wealthier than any other group, and \$500 is not going to devastate anybody. So I do not think it is worth the higher premium that everyone would have to pay.

Chairman STARK. Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

Mr. Burke, for the record, I would appreciate it if you could submit to us a comparison of your figures, which you just gave Mr. Daub and the CBO's figures regarding estimated revenues from the income-related financing mechanism of Stark-Gradison over the next 3 fiscal years. It appears that the CBO figures for estimated receipts are substantially lower than the ones you gave us. We would appreciate it if you would take a look at that.

Mr. BURKE. CBO numbers?

Mr. GRADISON. Excuse me. I misspoke. The cost figures for the two, and I would like to have a comparison of why these are as different as they are. In the first year, the difference is 2.2 versus 4.1, just as an example.

If you have the information now, fine, but the differences are so substantial we want to make sure why.

Mr. BURKE. Well, it is due to the lower out-of-pocket costs for Stark-Gradison.

You have a lower out-of-pocket cap with Stark-Gradison than we do in our bill.

Mr. DAUB. Would the gentleman allow me a moment?

Mr. GRADISON. Yes, of course.

Mr. DAUB. The question I asked Mr. Burke was to give me the costs. He has 3-year figures on the President's, and he compared them—if I recall correctly—to the first 3-year costs of Stark-Gradison.

Mr. BURKE. Correct.

Mr. DAUB. I think those are the two columns: the President's and Stark-Gradison's.

Mr. GRADISON. Well, those I can understand.

Mr. DAUB. Yes. I do not think he meant the difference between the CBO and their shop on their plan.

Mr. GRADISON. Mr. Chairman, may we submit this question in writing and ask that the response be included in the record of this hearing?

Chairman STARK. Yes, I would appreciate getting that too. Tom, if you would be willing to, then we could straighten it out for the record.

Mr. BURKE. Certainly.

[Information follows:]



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Office of the Assistant Secretary
for Legislation
Washington, D.C. 20201

JUL 31 1987

The Honorable Fortney H. Stark
House of Representatives
Washington, D.C. 20515

Dear Mr. Stark:

Thank you for your letter to Chief of Staff, Thomas Burke, forwarding concerns raised by Mr. Gradison during the Subcommittee hearing on March 30, regarding discrepancies between this Department's and the Congressional Budget Office's (CBO) cost estimates for the Stark-Gradison Medicare Catastrophic proposal. I regret that my response has been delayed.

The information you requested is attached. We appreciate the opportunity to address Mr. Gradison's concern.

Sincerely yours,

Patricia Knight
Deputy Assistant Secretary
for Legislation (Health)

Attachment

The estimates referred to by Mr. Gradison are not the estimates for the latest version of the Stark-Gradison proposal. Furthermore, the CBO has since advised us that they have different estimates. The latest estimates from the Department and the CBO for the Stark-Gradison proposal on a comparable basis are much closer and are listed below:

Estimated Cost for the Stark-Gradison Proposal ^{1/}
(\$ in Billions)

<u>Fiscal</u> <u>Year</u>	<u>Department</u>	<u>CBO</u>
1988	\$1.4	\$1.1
1989	4.0	3.7
1990	5.2	5.5

^{1/}The projections for FY 88 - 90 do not include administrative costs or premium offsets.

The discrepancy in the current estimates is probably due to the different data files used as the basis for projections. The CBO used a later but more incomplete file which would tend to underestimate the number of actual coinsurance and lifetime reserve days for inpatient care. Hence, the CBO estimates are lower in the early years. In addition, CBO assumes greater increases in the Medicare baseline which would cause their estimates to be higher than the Department's in the outyears.

Prepared by the Office of the
Actuary, HCFA
April, 1987

QUESTION FROM MR. GRADISON TO MR. TOM BURKE:

There is a discrepancy between the Department's and the CBO's cost estimates for the Stark-Gradison Medicare catastrophic proposal.

When Mr. Daub asked for the Department's cost estimates for the the President's and the Stark-Gradison proposals, you cited the following statistics:

ESTIMATED COSTS OF THE MEDICARE CATASTROPHIC PROPOSALS
FROM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

(In billions of dollars)

	President's	Stark-Gradison
CY88	2.3	4.1
CY89	2.5	4.7
CY90	2.9	5.7

The Department's cost estimates for the Stark-Gradison proposal differ substantially from the cost estimates calculated by the CBO. The CBO estimates are:

ESTIMATED COSTS OF THE STARK-GRADISON PROPOSAL FROM THE
CONGRESSIONAL BUDGET OFFICE

(In billions of dollars)

	Stark-Gradison
FY88	2.2
FY89	3.7
FY90	4.6

I understand the Department's figures are based on a calendar year and the CBO figures use a fiscal year. But it seems unlikely that the 12-month period used could account for the marked difference between the cost estimates.

- o Why is there such a substantial difference between the two cost estimates?
- o What assumptions made by either the Department or the CBO might account for the discrepancy?

Chairman STARK. Are there any further inquiries? If not, Tom, thank you very much for postponing or voiding your Florida trip and being here with us this morning. I am not sure that the next witness will agree with me that you are better off here than in Florida because he has come here from Florida, and he is our former colleague who was, I believe a member of our class of the 97th—93rd with me.

It is a pleasure to welcome Commissioner Bill Gunter, the insurance commissioner of the State of Florida, who is accompanied by Commissioner Earl Pomeroy, the insurance commissioner of the State of North Dakota.

As the witnesses change seats, I notice Bill is just at the edge of the room. We will take a moment.

When the two witnesses are seated and comfortable, we will ask them to proceed in the order they appear on the witness sheet. And, Bill, we have your prepared statement, and I am sure we would all like to inquire. So I am going to ask you if you would mind summarizing and expanding on your statement in any manner you are comfortable, and we will proceed from there. Welcome.

Mr. ANTHONY. Mr. Chairman, may I be recognized?

Chairman STARK. Certainly. Mr. Anthony.

Mr. ANTHONY. Thank you, Mr. Chairman.

Commissioner Pomeroy, Congressman Dorgan was in the room hoping that he could stay long enough to hear your testimony and introduce you before the subcommittee. But, unfortunately, he had a previous engagement that took him away.

He asked me if I would say welcome to the commissioner and tell this subcommittee what a great American and what a great individual you are, and what a great insurance commissioner you are.

So thank you, Mr. Chairman.

Chairman STARK. Thank you very much.

Bill.

STATEMENT OF BILL GUNTER, INSURANCE COMMISSIONER, STATE OF FLORIDA, ACCOMPANIED BY EARL R. POMEROY, INSURANCE COMMISSIONER, STATE OF NORTH DAKOTA, BOTH ON BEHALF OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS; AND DALE HAZLETT, HEAD OF DIVISION OF INSURANCE RATING, FLORIDA DEPARTMENT OF INSURANCE

Mr. GUNTER. Mr. Chairman, members of the subcommittee, as the chairman has indicated, my name is Bill Gunter, insurance commissioner of Florida, speaking for the National Association of Insurance Commissioners.

With me is the distinguished Earl Pomeroy, insurance commissioner of North Dakota, and chairman of the NAIC State and Federal Health Insurance Legislative Policy Task Force. I also have with me sitting at the desk Dale Hazlett, who is the head of the Division of Insurance Rating in the Florida Department of Insurance.

Mr. Chairman, the Medicare Supplement Long-Term Care, and Other Limited Benefit Plans Task Force of the NAIC, and as insur-

ance commissioner of a State where the ability of the elderly to sustain health and dignity in later years is of critical interest, I appreciate the opportunity to speak on these issues today.

In 1980, in response to the Baucus amendments to the Social Security Act, the NAIC adopted a model statute and regulation in Medicare supplement insurance that has been enacted by States across the country. Those standards spell out minimum coverage and deductibles, free looks, including the rights of consumers there-to, marketing practices, loss ratio targets, and consumer information materials. These standards are now being met or exceeded in nearly every State and in the District of Columbia and in Puerto Rico.

We feel the standards have raised the overall quality of the Medicare supplement insurance product, as well as the level of consumer education.

The NAIC is also concerned about abuses and direct mail and mass marketing. A top priority this year for my Medicare Supplement Task Force is to produce NAIC model guidelines for Medicare supplement insurance marketing practices, and to draft an NAIC health insurance consumer guide for seniors.

This kind of consumer education provides the front line defense against marketing abuses like stacking of policies and the use of scare tactics or misrepresentation. When cases are uncovered, State regulators must have adequate legislative authority to level fines against the agents and the companies involved, or to suspend or revoke the agents' licenses.

As you know, the 1980 Baucus amendment also established targets for loss ratios on Medicare supplement policies of 60 percent for individual and 75 percent for group policies. The Federal law requires that companies demonstrate to the States that they fairly anticipate a certain loss ratio, but not that the loss ratio be specifically met.

Nevertheless, NAIC has developed a new reporting form now in use in Florida which monitors actual loss experience in the Medicare supplement lines. Using this data, we found that the individual so-called medigap policies in Florida average a 72 percent loss ratio.

As was indicated in a rapport to this subcommittee by the General Accounting Office, those companies that failed to reach the loss ratio targets are generally in the \$50,000 and lower premium bracket with small blocks of business that are volatile. Whether the Baucus amendment loss ratio targets are high enough is a question, the answer to which requires an understanding of actual loss ratio performances over time. That information will be available in considerable volume and detail to the new NAIC reporting form.

These are some of the issues that have been of concern to the NAIC in the present environment of Medicare and Medicare supplement insurance. As new legislation is brought forward, Mr. Chairman, like H.R. 1280 and H.R. 1281, which promises to change the shape of Medicare coverage, many of these issues will have to be revisited.

Among those issues will likely be a change in standards for coinsurance and deductibles, benefit periods, blood coverage, and bene-

fits for home care, eye and dental care. Modifications will have to be made in the coordinating coverages of Medicare supplement policies to help elderly consumers avoid unnecessary duplication of the new catastrophic care benefits.

The NAIC has already made a firm commitment to enact necessary changes within a 3-month period of the effective date of your new catastrophic health care plan. In the meantime, we enthusiastically offer our assistance as individual insurance commissioners and as members of the NAIC, in helping the Congress provide for the urgent public need of appropriate catastrophic health care coverage.

Thank you.

[The prepared statement follows:]

Testimony to the House Ways and Means Committee
 Subcommittee on Health

On Medicare Supplement and Catastrophic Health Insurance
 By The National Association of Insurance Commissioners

March 30, 1987

Florida Insurance Commissioner Bill Gunter
 Chairman, Medicare Supplement, Long-Term and
 Other Limited Benefit Plans Task Force

Mr. Chairman, Members of the Subcommittee, I am Bill Gunter, Insurance Commissioner of the State of Florida, speaking for the NAIC. With me is Earl Pomeroy, Commissioner of Insurance of the State of North Dakota and Chairman of the State and Federal Health Insurance Legislative Policy Task Force.

As Chairman of the Medicare Supplement, Long-Term and Other Limited Benefit Plans Task Force of the National Association of Insurance Commissioners, and the Insurance Commissioner of a state where the ability of the elderly to sustain health and dignity in later years is of critical interest, I appreciate the opportunity to share with you our insights and concerns on this important issue.

The complexity of the interrelationships between Medicare coverage, and the coverage provided by a wide spectrum of Medicare supplement health insurance plans calls for a greater level of consumer advocacy from government on behalf of our elderly than perhaps any other insurance consumer group.

NAIC Model Statute

In 1980, in response to amendments to the Social Security Act, the NAIC adopted a model statute and regulation that have been enacted by states across the country. The minimum standards contained therein include:

- * coverage of all Medicare hospital coinsurance through lifetime reserve days, plus 90 percent of an additional 365 hospital days;
- * coverage of all Part B physician coinsurance (20 percent) up to \$5000 after a \$200 deductible;
- * provision of a "free look" period (10-30 days) during which time the policy can be returned for a full refund;
- * coverage of pre-existing conditions after a 6-month waiting period;
- * fair trade practices such as simplified policy language and truth-in-advertising;
- * minimum loss ratios of 60 percent for individual policies and 75 percent for group policies (based on a lower expense component for the latter); and
- * provision, at the time of sale, of a buyers guide explaining benefits and limitations of Medicare and Medicare Supplement Insurance.

These standards are now being met or exceeded in nearly all states, and in the District of Columbia and Puerto Rico. We feel that the standards have raised the quality of the insurance product, as well as the level of consumer education.

Marketing Practices

Insurance departments across the country encourage senior citizens to report insurance problems, including possible marketing abuses to their complaint-handling divisions. That message is carried in the consumer guides, senior citizen forums and programs like our Consumer Outreach Program in Florida, or the Senior Health Insurance Benefit Advisors in Washington State.

Along those same lines, NAIC produced a public service announcement last year informing seniors of the existence of complaint-handling facilities. My NAIC Task Force is drafting a Health Insurance Consumer Guide for seniors which will be circulated nationwide. The NAIC also co-publishes a Guide to Health Insurance for People with Medicare.

This kind of consumer education provides the front-line effort against abuses like stacking of duplicative coverage and the use of scare tactics or misrepresentation. When cases are uncovered, fines, suspension or revocation of the agent's license are among the enforcement tools available to the states.

Over the ten years I have been Florida's Insurance Commissioner, we have revoked or suspended the licenses of more than 1100 insurance agents for improper practices, fining or placing on probation more than 500 more. Insurers and agents violating Florida's insurance laws and regulations have been fined over \$1 million in the last six years.

The NAIC is also concerned about abuses in direct mail and mass-marketing practices. The Medicare Supplement, Long-Term and Other Limited Benefit Plans Task Force, of which I am Chairman, has a top priority the charge of looking at abuses in that area and formulating effective actions.

Other states in addition to Florida are actively engaged in enforcing high standards in marketing practices. In your state, Mr. Chairman, recently the California Insurance Department required all insurers to submit their advertising files for review as to whether their marketing practices complied with state law. Florida along with some other states taking such action are Ohio, Washington and Minnesota. Many states also conduct market conduct examinations.

The Arizona Department recently issued a guideline specifying filing procedures for advertising and sales solicitation material for health insurance. The guideline specifies that scripts must accompany tapes of television ads and that audio cassette tapes accompany proposed radio ads. An explanation of intended usage must also accompany certain printed advertising and sales material.

My Medicare Supplement Task Force will be producing an NAIC model to specify advertising guidelines for filing procedures on advertising aimed at Medicare-eligible consumers.

Loss Ratios

The Baucus Amendment established targets for loss ratios on Medicare supplement policies of 60 percent for individual policies, and 75 percent for group policies. Federal law requires that companies demonstrate to the states that they fairly anticipate a certain loss ratio but not that the loss ratio be specifically met.

Nevertheless, several states including Florida do monitor actual loss experience as part of the rate review process. These reviews are conducted to assure that premiums purchasers pay for Medicare supplement insurance will be no more than necessary to provide the benefits offered.

The October 1986 study on medicare supplement insurance by the General Accounting Office found that while not all policies hit the target loss ratios, those with the highest volume of earned premium actually exceeded the targets.

The question of whether the targets are high enough is one that has been raised more than a few times. From an actuarial point of view, the tendency of the loss ratio for a given policy to rise at an increasing rate as the insureds grow older generally require a lower loss ratio earlier in the policy to compensate. Still, this something that should constantly be re-examined as experience is gathered.

A new reporting form is now being considered by NAIC which is designed to collect data nationwide which will enable an evaluation of lifetime loss ratios as opposed to ratios over a limited period of time.

This concept of lifetime loss ratios producing "mature experience" was one addressed by many of the states to the GAO and subsequently reflected in their report, along with the actions already taken by states to gain this valuable perspective.

Long Term Care Insurance

In 1984, the increasing national concern over the financing of long-term care and the limited availability of insurance products to fulfill the long-term care needs prompted the NAIC to expand the charge of its existing Medicare Supplement and Other Limited Benefit Plans Task Force to include these issues.

Today the structure of long-term care financing is limited in large part to public assistance programs. The demographic trend of an increasing elderly population, especially in my own state, the continued technological advances in medicine, and the tendency on the federal level to limit spending on social programs have led many states to look for solutions within the private sector.

Therefore, the Task Force examined the feasibility of expanding conventional coverage to include reimbursement for long-term care services, collecting of actuarial data to determine pricing, alternative funding mechanisms and other legislative action that might encourage the development and marketing of such a product.

In 1986, legislation on long-term care insurance was implemented in 14 states. Some legislatures have directed their legislative research facilities to conduct studies on how to promote the development of long-term care policies. Others have revised or established benefit standards or have mandated long-term care coverage.

In late 1986, a subgroup of the Task Force developed a long-term model act designed to promote the availability of long-term care policies and to protect the public by setting certain standards for included care. The model addresses performance and disclosure standards, cancellation terms, pre-existing condition limitations, prior institutionalization requirements and the policyholder's right to return the policy.

Several states are considering adoption of the NAIC long-term care model. Among them are Arizona, Indiana, Iowa, Kansas, North Dakota and Virginia. Several states have already enacted legislation similar to the NAIC model.

Federal Catastrophic Care Legislation

Today, we stand at the brink of new federal legislation providing a higher standard of catastrophic care under the coverage provided by Medicare. As these efforts go forward, it will be necessary to revisit these actions as well as the Medicare supplement policy standards. We have studied HR 1280 and HR 1281, Mr. Chairman, along with the legislation put forward by Senator Kennedy, Senator Dole, Representative Pepper, and Representative Roybal among others.

Some of the issues that will have to be addressed will be to change the standards relating to coinsurance and deductibles, benefit periods, the deductible for blood coverage, and benefits for home care, eye and dental care. NAIC has made a commitment to enact necessary changes within three months of enactment.

As legislation develops that changes the shape of Medicare coverage, changes will have to be made in the coordinating coverages of Medicare supplement policies. Efforts will also have to help elderly consumers avoid unnecessary duplication of the new catastrophic care benefits with supplemental coverage. Many of the proposals you are considering, for example, would limit Medicare deductibles and out-of-pocket expenses. Under the current Medicare standards a Medicare supplement policy would provide overlapping coverage. The duplicate coverage and the premium charged for it is an issue which should be addressed.

In the meantime, we enthusiastically offer our assistance as individual insurance commissioners, and as members of the NAIC in helping the legislative process serve the urgent public need for adequate catastrophic coverage.

Chairman STARK. Bill, thank you very much.

The indemnity policies in, and I guess you call them disease policies, are sold—I guess Danny Thomas is one of their best salespeople. It is my understanding they are not regulated either by your group, NAIC, or the Baucus amendment.

Will your guidelines include these indemnity and disease policies that are aimed at the Medicare eligible population?

Mr. GUNTER. I am sorry. The last part of your question?

Chairman STARK. Will the guidelines that you are going to come out with include these indemnity and disease policies that are aimed, I presume, at the Medicare population?

Mr. GUNTER. Yes, sir, they will. We do not plan to exclude any form of Medicare supplement coverage as to our consumer guide or buyer guide.

Chairman STARK. Do you suppose we should include those types of policies in the Baucus amendment?

Mr. GUNTER. That is a policy decision obviously that the Congress will appropriately make. We do intend, through the NAIC, to incorporate that brand of medigap policy in our own consumer information effort.

Mr. POMEROY. Mr. Chairman, if I might.

Chairman STARK. Please.

Mr. POMEROY. The committee, which is chaired by Commissioner Gunter, as well as two other NAIC committees, are reexamining this whole issue of mass marketing of limited policies which seems to be accelerating——

Chairman STARK. Is that the definitional word of what I am talking about?

Mr. POMEROY. Limited benefit, yes.

Chairman STARK. Okay.

Mr. POMEROY. And we expect that there will be increasing efforts at the State regulatory level to get a handle on making sure these policies are offering a reasonable priced benefit for the cost of the premium. There is tremendous pressure at the regulatory level, at the State legislative level, as well as significant congressional interest in the proliferation of this mass marketing. And the NAIC is responding with three committees at present.

Chairman STARK. To either or both of you, as you well know, your industry is one that these fools have not rushed into, with you angels out there treading in that area of insurance regulation. But I have often wondered if there are areas in which we might be helpful as the population becomes more mobile, and as we have more Federal benefits that are integrated with various types of insurance programs that tend to be uniform.

Are there areas of Federal standards, for example, that would help you in your business of regulation? Now, there is no particular committee of jurisdiction, and I am not trying to jump ahead of any other committee here. Our obvious handle on that is the Tax Code or indeed the Medicare program which would have some effect on health or medical insurance. So I ask it in a sense that if there is, we could cooperate.

For example, and this is the second part of the question, I do not suppose it makes any difference what the minimum benefit requirements are in a policy if we have a minimum or payback. In

other words, as long as the company returns x percent of the premiums in benefits, what do we really care what the benefits are? Obviously we would like to help the consumer buy things that are usable. But if you have to return 85 or 90 percent of your premium in benefits, is there really a reason to regulate the benefits and, secondly, might that be something we could establish federally? Maybe require that you have got to have 85 percent of the premium returned. You all then determine whether the contract reads right and the company is solid.

Mr. GUNTER. Mr. Chairman, one of the things that I think will be very helpful to the NAIC and the individual insurance commissioners in discharging our responsibility is this new reporting form that I mentioned in my brief testimony wherein we in Florida now are developing, and many other States as well, under the auspices of the auspices of the NAIC are developing actual loss experience of a maturing kind so that we can, in effect, see what that loss experience is as to specific Medicare supplement insurance plans.

Then, rather than to try to kind of pluck a figure out of the air, so to speak, we will have data that is real that some judgments from regulatory standpoint can be effectively made.

Mr. POMEROY. Mr. Chairman, if I might, too, I think that Congress has been very helpful. The Baucus amendments, for example, in terms of getting the States up to speed in imposing adequate regulation of this product has been very helpful, and the NAIC is committed to adopting the Baucus requirements to match whatever new catastrophic benefit is passed within 3 months of the congressional action. So that has been helpful to the extent any catastrophic plan passed seems to place a maximum stop loss on an individual's exposure under Medicare, thereby making it easier for an individual to understand what the Medicare program is. That helps.

The more understandable Medicare is, the easier it is to regulate the Medicare supplement marketplace. So that is very helpful.

The issue of congressional mandating of loss ratios is deceptively simple I think. It is a way to completely disrupt the marketplace. Obviously, if the industry cannot see how to write a product and make a profit, then there will not be a product available.

There are areas where individuals should have the opportunity to buy insurance, and you run the risk of interfering with that by imposing loss ratios. We like to think that at a State regulatory level, we can keep an eye on those loss ratios and make sure they are adequate without, at the outset, saying what they should be, and then preventing a marketplace from developing.

Chairman STARK. Okay. Now, let me talk about something prospectively which we dropped in your laps, I suppose, whether you like it or we like it. And I would like your suggestions here.

We are under some pressure to begin to increase the issuance of HMOs, whether it is through a voucher system or through the payment of Medicare to HMO organizations.

I know Mr. Gunter is very familiar with some problems that we have had, with a big one in Florida, with a cash flow of maybe \$30 million a month.

To get into an HMO, as I understand, you have got to have 10,000 people if it is going to qualify for Medicare, and that almost

means a \$2.5 million a month cash flow. And there is some insurance in that. It is conceivable that you and I, and an IBM computer, could start an HMO, and qualify for that payment. All you have got to do is find 10,000 enrollees. There are no laws right now. And what I could do with that \$2½ million coming in each month is start our nonprofit medical school in the Bahamas and fly down there in our HMO's private jet. We would probably leave a few unhappy doctors behind whose bills we did not pay, but that is not a Federal law. I mean that is against that.

I suppose there are some racketeering statutes.

I would assume there is some insurance in the HMO concept, certainly in the short run. I mean they have got to stay in business a year. And there are big financial stakes, and HCFA is not very adept at regulating financial institutions. There are no standards for how much reserves are necessary.

What are we going to do as we encourage more use of that and then find the business community coming in to provide this kind of quasi, half insurance, half hospital health program? Do you want to regulate them? Do you want us to write the guidelines? We would pay for it, and you would regulate it under our guidelines? What kind of help can you give us in that area?

Bill?

Mr. GUNTER. Mr. Chairman, I would point out, as I am sure you and the committee are aware, that we have enacted in Florida now some State guidelines and requirements, including, in fact, some reserving.

Now, it is not as high as you or I would prefer that the reserving requirements be. But—

Chairman STARK. Can I interrupt just a minute?

Is there a way that you all, with your actuaries and staff and your accountants, could predict a reasonable reserve level at which you would be comfortable?

Mr. GUNTER. We certainly think we can.

Chairman STARK. Because I think that is going to be important to us as we begin to pay for this. After all, we are going to be the ones paying the bills for the Medicare beneficiaries.

Mr. GUNTER. We certainly believe we can do that. That is obviously a growing industry now in Florida and throughout the United States with the Federal participation as it has been enacted and approved.

The NAIC does in fact have a model Health Maintenance Organization Act. It continues to be reviewed and amended and tightened up and I think improved.

For example, just this past December, in Orlando, at our national meeting, we added additional cash management guidelines and requirements relating to cash, securities, commingling of funds, and the like, which was a part of the problem that we faced with respect to the entity that you are familiar with in Florida. So we do feel, as you do, that there is a tremendous problem area, and the Federal Government and the States have a partnership and need to move forward together.

Chairman STARK. But I am telling you this is right on the edge right now. I mean we are anticipating more legislation on this, if not this year, next.

My question is, what do you two think would be the best way? Should we mandate some standards and hope that the insurance commissioners will regulate it? Should we do our own reserve standards which might be tougher than yours, and set a pattern which you would like to follow?

I have a hunch if we set reserve standards, the States are going to be hard-pressed to set them lower for non-Medicare standards. Maybe not. I do not know. But what is the best way for us? When you talk about a partnership, who picks up which end of the bale here as we are doing the lifting? That is my question.

Mr. POMEROY. Mr. Chairman, I think it has got to be a shared lift. I think that the insurance departments have worked it and the National Association of Insurance Commissioners have developed a model. In addition, we have addressed the issue——

Chairman STARK. You have a model now for HMO regulations?

Mr. POMEROY. Yes, we do.

We have addressed the issue of insolvent HMO's through our guarantee funds, looking at the——

Chairman STARK. I do not know whether we have copies of that, but we would certainly like to see it.

Mr. GUNTER. We will provide that for you.

Chairman STARK. Would you? I would sure appreciate it for the record and my personal curiosity.

Mr. GUNTER. Absolutely.

Mr. POMEROY. We certainly will.

[Information follows:]

NAIC

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Kansas City, Missouri 64106
816-842-3600

National
Association
of Insurance
Commissioners

March 31, 1987

The Honorable Fortney H. Stark
Chairman, Subcommittee on Health
Ways and Means Committee
1114 Longworth House Office Building
Washington, D.C. 20515

Re: NAIC Models on the Regulation of Health Maintenance Organizations

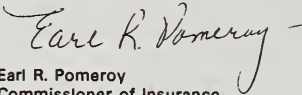
Dear Mr. Stark:

As you requested, we are enclosing a copy of the NAIC models to which we referred in the NAIC's testimony before your Subcommittee. We appreciated the opportunity to represent the NAIC on the issue of Medicare and Catastrophic Illness and reiterate our willingness to assist the Subcommittee in its deliberations.

Sincerely,



Bill Gunter
Commissioner of Insurance
State of Florida



Earl R. Pomeroy
Commissioner of Insurance
State of North Dakota

Enclosures

cc: Ms. Gwen Gampel

Model Health Maintenance Organization Act**Table of Contents.**

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Section 1. Short Title.

This Act may be cited as the Health Maintenance Organization Act of (insert year).

Introductory Comment.

The rising cost of health services in recent years has led government agencies, private organizations, and legislative bodies to seek alternatives to the traditional medical delivery system which will provide improved health care at a lower cost. The health maintenance organization is a concept which has received much attention as one means through which an improvement in delivery might be achieved.

Shortcomings of Existing Health Care Delivery System

The health care delivery system as it is now constituted presents several problems. First, many people are unable to obtain health care when they need it and in the form they need it. This problem can be divided into three subareas: (a) In many areas of the country, the availability of health care in terms of the quantity of manpower and facilities is inadequate; (b) Even where physicians, nurses, clinics, and hospitals do exist, they may lack accessibility due to poor location, poor management, lack of transportation, language or racial barriers, inconvenient hours, etc; and (c) Even if health care is available and accessible, it may not be continuous: that is, a single patient may not be treated as a person with a continuing or a variety of problems but rather as a single isolated health care problem incident. The problems of availability, accessibility, and continuity, at least in part, have been attributed to the lack of responsibility vested in one person, group, or organization to assure the delivery of health care.

HMO Act

A second problem is the escalating cost of health care services. This stems from the limited supply of health care service facilities which is confronted by an expanded and fragmented financing mechanism and the consequent tremendous increase of demand for such services. This is the classic model for inflation. Traditional reimbursement of providers by the federal government, insurance plans, and hospital and medical service corporations, because of the inherent difficulties involved, has been accompanied by uneven efforts toward ineffective cost review or control. Furthermore, services or facilities are often duplicated or used inefficiently. A basic cause of inflation and inefficiency rests with the improper structuring of incentives. Where no individual, group, or organization is responsible for the use of more economical services and facilities, including those relating to preventive care, greater income is generated for providers by the more frequent use of services and facilities and by the use of the more expensive facilities and services available.

A third problem is the quality of health care delivered. Throughout various parts of the country, the quality of health care can range from the very best to the very poor. Generally speaking, there is no locus for quality assessments either as to health care processes or health care results. In the absence of a means to measure quality, it is virtually impossible to design and implement effective programs to rectify defects.

This brief discussion in no way attempts to provide a comprehensive discussion of the problems of the health care delivery system in the United States nor does it give adequate recognition to the strenuous efforts of many to improve the existing system. However, it does highlight some of the major problems prevailing today. Development of the health maintenance organization (HMO) concept offers one alternative means to help alleviate some of these problems. What then is an HMO?

Nature of the Health Maintenance Organization

A health maintenance organization may be described as an organization which brings together a comprehensive range of medical services in a single organization to assure a patient of convenient access to health care services. It furnishes needed services for a prepaid fixed fee paid by or on behalf of the enrollees. An HMO can be organized, operated, and financed in a variety of ways. For example, an HMO may be organized by physicians, hospitals, community groups, labor unions, government units, insurance companies, etc. Generally speaking, an HMO delivery system is predicated on three principles. (1) It is an organized system for the delivery of health care which brings together health care providers. (2) Such an arrangement makes available basic health care which the enrolled group might reasonably require, including emphasis on the prevention of illness or disability. (3) The payments will be made on a prepayment basis, whether by the individual enrollees, medicare, medicaid, or through employer-employee arrangements.

How might the HMO concept contribute to alleviating the difficulties posed by the current health care delivery system?

An HMO can directly address itself to the problems of availability, accessibility, and continuity, since it is a health care delivery system. It assumes responsibility for actually furnishing to its enrollees those health care services necessary to meet the obligations it undertakes. Thus the HMO occupies a position through which both the accessibility and continuity of care may be affected.

An HMO, by its very nature, may provide incentives toward lessening costs in delivering health care. It has a limited membership prepaying fixed sums of money. The providers are obligated to deliver a specified set of health care services. The fixed amount of income provides incentive to control expenses and costs. The HMO provides a mechanism to analyze costs, expenses and utilization of services, and affords a means to implement measures to enhance efficiency.

The problem of the quality of health care is not susceptible to an easy solution. An HMO is in a position to assess the quality of care provided since it is a closed system. It can study the health of its members, review the records of treatment, and in general, provide a monitoring mechanism.

Medical Care Foundations

A variation of the HMO concept is seen in some medical care foundations. Although individual foundations differ greatly in detail, a foundation for medical care is usually sponsored and organized by a county or state medical society. The membership consists of physicians who apply to and are accepted by the foundation.

Those medical care foundations which can be considered as a variant of the HMO concept, often contract with an insurer or other prepayment plan (e.g., hospital or medical service corporations) to provide coverage meeting certain minimum criteria consistent with the delivery of quality medical care. The insurer collects the premiums, promotes, markets, and underwrites the program. The enrollee may seek physician services from any member of the foundation who then bills either the insurer or the foundation, not the enrollee. Although such billings are on a fee-for-service basis, the amount charged the enrollee is fixed and prepaid without regard to the number or type of services used. The foundation establishes some form of peer review to monitor not only the level of charges but also the type and quality of care rendered. Since the amount of income does not vary with the number or type of services provided, incentives exist to maintain costs at as low a level as possible. However, unlike the HMO concept described above, even though physician services are prepaid from the patients' viewpoint, from the physicians' viewpoint, the fee-for-service practice is maintained. Under the federal HMO Act, this type of organization is called an Individual Practice Association Type HMO.

The Need for State Authorizing and Regulatory Legislation

From 1970 to 1973, the administration and committees in both houses of Congress spent much time analyzing the health maintenance organization alternative in connection with national health insurance and federal assistance bills for HMO's. This analysis resulted in the enactment of the federal HMO Act in 1973. Since then, the number of health maintenance organizations and the number of HMO enrollees has grown rapidly. Prior to 1972, however, few states had a statutory framework tailored to the supervision of health maintenance organizations. Chartering, licensing, contract and rate regulation, and other supervision was being carried out under general insurance laws, hospital and medical service corporation statutes, other special statutes, or not at all. Because the HMO is a unique type of organization, many provisions of such state laws were inapplicable, highly restrictive or prohibitive to the formation and operation of an HMO. Therefore, in 1972 the NAIC adopted the Model Health Maintenance Organization Act which accommodates the unique features of HMO's.

Purpose of a State Model Bill

The model bill clearly authorizes the establishment and operation of HMO's. Restrictive provisions in other laws which are inappropriate to HMO's are rendered inapplicable. Appropriate grants of authority are established to enable the HMO's to fulfill the function envisioned for them. At the same time, however, the public has a vital interest in the fiscally sound, efficient, and ethical operation of HMO's. As is the case with insurance and hospital and medical service corporations, HMO's are "affected with the public interest." Regulatory safeguards dovetailed to the unique nature of HMO's are essential. Thus, the purpose of this model bill is twofold.

First, it attempts to provide a legal framework enabling the organization and functioning of HMO's of a wide variety including those based upon the medical care foundation or individual practice association concept. The legal environment is designed to permit a high degree of flexibility. No one form of organization or one type of *modus operandi* is required. Instead the HMO concept can be refined and subjected to further experimentation. Second, the model bill attempts to provide a regulatory monitoring system not only to prevent or remedy abuse, but also to assist in the future improvement and development of this alternative form of a health care delivery system.

Of course, it is also possible that the statutes of a given State are presently broad enough to allow operation of at least certain types of HMO's and provide the commissioners with appropriate authority to regulate them. In those states, a bill such as this may be desirable in order to consolidate and define more clearly the authority for and manner of regulation of an HMO. However, it may be possible to form HMO's under existing laws in some states before passage of this model legislation and it is anticipated that such programs can develop concurrently with any legislative activity.

HMO Act

Since the model bill was approved, the federal HMO Act has been enacted and amended four times. The model, or substantial portions of it, has been enacted in 27 states and substantial experience has been gained in implementing and regulating HMO's under its terms. In addition, a few HMO's have become insolvent and commissioners have had to deal with the results of those insolvencies. Therefore, the model act has been revised to reflect changes which have occurred in the federal law, to reflect experience gained in administering the law and to clarify and strengthen the provisions relating to HMO solvency.

It may be necessary to modify or replace certain language in the model bill prior to legislative consideration to make terminology consistent with existing law in a particular state. To simplify this adjustment, three frequently used terms known to be subject to variation from state to state are enclosed in parentheses wherever used in order to facilitate necessary modification. These terms are: (1) commissioner, whose counterparts in some states are known as director or superintendent; (2) commissioner of public health, whose counterparts in other states are known as director of public health or by some other title; and (3) hospital or medical service corporations, whose counterparts in other states may be known as health service corporations, hospital indemnity corporations, etc. Where specific reference to existing state laws is required, the nature of the citation is indicated parenthetically.

The model bill provides that the principal regulator is the commissioner of insurance. It may be desirable for the commissioner to have an advisory council to advise him in carrying out his duties under the act. Such an advisory council could be established through the promulgation of a regulation pursuant to Section 20 of the model bill or by adding a new section to the model bill.

Section 2. Definitions.

- (1) "Commissioner" (director, superintendent) means the commissioner (director, superintendent) of insurance.
- (2) "Basic health care services" means emergency care, inpatient hospital and physician care, and outpatient medical services. It does not include mental health services or services for alcohol or drug abuse.
- (3) "Enrollee" means an individual who is enrolled in a health maintenance organization.
- (4) "Evidence of coverage" means any certificate, agreement, or contract issued to an enrollee setting out the coverage to which he is entitled.
- (5) "Health care services" means any services included in the furnishing to any individual of medical or dental care, or hospitalization or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability.*
- (6) "Health maintenance organization" means any person that undertakes to provide or arrange for basic health care services to enrollees on a prepaid basis. The organization may provide physician services directly through physician employees or under arrangements with individual physicians or a group or groups of physicians. The organization may also provide or arrange for other health care services on a prepayment of other financial basis.
- (7) "Person" means any natural or artificial person including but not limited to individuals, partnerships, associations, trusts, or corporations.
- (8) "Provider" means any physician, hospital, or other person which is licensed or otherwise authorized in this state to furnish health care services.
- (9) "Uncovered expenditures" means the costs of health care services that are covered by a health maintenance organization, for which an enrollee would also be liable in the event of the organization's insolvency.

*Editor's Note: Amended in 1974 by adding "physical disability." See 1974 NAIC Proceeding (413).

Comment. Subsection (6) defines an HMO to be any person that undertakes to provide or arrange for at least basic health care services on a prepaid basis. This can be achieved either (a) by providing the services directly through physician or other providers actually employed by the HMO and through hospitals or facilities owned or directly operated by the HMO, or (b) by contracting or arranging with physicians, hospitals or other facilities to provide such services. The term "arrange" does not contemplate those traditional arrangements which hospital or medical service corporations make in conjunction with their prepayment service plans pursuant to hospital or medical service corporation laws. If it were otherwise, the traditional hospital and medical service corporation prepayment service plan, by itself, would be an HMO.

Subsection (2) defines basic health care services. This definition, combined with the requirement that an HMO provide for basic health care services in Sections 4(2)(c) and 18(1)(c), establishes a minimum package of health care services which an HMO must provide or arrange for. This is intended to assure that the enrollees obtain at least a sufficiently broad range of services to meet a reasonable amount of their health care needs. At the same time, however, the definition should not be so broad as to be financially prohibitive to a substantial number of enrollees. Services for mental illness and alcohol and drug abuse are not included because they are often not covered by insurance or hospital or medical service plans and their inclusion would create a competitive disadvantage of HMO's. If a state believes that such services, or others, should be included as basic health care services, all carriers in the state should be required to offer or cover them.

Since no HMO may function without either a certificate of authority (see Section 3(1)) and since an HMO must furnish basic health care services (see Section 4(2)(c)), no health care services may be provided or arranged for on a prepaid basis without the minimum package of basic health care benefits. This serves two purposes: (a) it requires the provision of adequate protection and (b) it prevents the avoidance of the applicability of the Act by the mere expediency of failing to meet the minimum package requirements.

In addition, the HMO may furnish additional services, certain limited indemnity benefits and more comprehensive indemnity benefits. (See Section 5(1)(f).) These additional services and benefits can be put together in any one of a variety of ways. The indemnity or service benefits might cover such situations as out-of-area emergency services, out-of-area benefits for dependents away at college, or services which the affiliated providers lack the capacity to make available. This flexibility in piecing together the package of coverage through direct and indirect services and indemnity benefits enables an HMO type operation to meet health care needs in a wide variety of circumstances.

The definition of an HMO affords wide latitude for different arrangements. This highly flexible approach seems best suited to our diverse and pluralistic society with problems varying from locality to locality. Flexibility will allow continued innovation and experimentation with different organizational structures. It may be easier to recruit health personnel if a number of alternative approaches are available. Consistent with this philosophy is the absence of any requirement of a minimum number of employees or of a mandate as to whether or not the HMO should be a profit or non-profit organization. Permitting both profit and non-profit organizations will broaden the financial and managerial resources which can be drawn upon in developing the HMO concept.

Subsection (9) defines uncovered expenditures for use in Section 13. These are expenditures for health care services for which the HMO is at risk. They will vary in type and amount, depending on the arrangements of the HMO. They may include out-of-area services, referral services and hospital services. They do not include expenditures for services when a provider has agreed not to bill the enrollee even though the provider is not paid by the HMO, or for services that are guaranteed, insured or assumed by a person or organization other than the health maintenance organization.

Section 3. Establishment of Health Maintenance Organizations.

- (1) Notwithstanding any law of this state to the contrary, any person may apply to the commissioner (director, superintendent) for and obtain a certificate of authority to establish and operate a health maintenance organization in compliance with this act. No person shall establish or operate a health maintenance organization in this state, without obtaining a certificate of authority under this act.* A foreign corporation may qualify under this act, subject to its registration to do business in this state as a foreign corporation under (insert citation).
- (2) Every health maintenance organization as of the effective date of this act shall submit an application for a certificate of authority under Subsection (3) within (insert number) days of the effective date of this act. Each such applicant may continue to operate until the commissioner (director, superintendent) acts upon the application. In the event that an application is denied under Section 4, the applicant shall henceforth be treated as a health maintenance organization whose certificate of authority has been revoked.
- (3) Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the commissioner (director, superintendent), and shall set forth or be accompanied by the following:
 - (a) A copy of the organizational documents of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;
 - (b) A copy of the by-laws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;
 - (c) A list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association;
 - (d) A copy of any contract made or to be made between any providers or persons listed in Paragraph (c) and the applicant;
 - (e) A copy of the form of evidence of coverage to be issued to the enrollees;
 - (f) A copy of the form or group contract, if any, which is to be issued to employers, unions, trustees, or other organizations;
 - (g) Financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent (regular) certified financial statement shall be deemed to satisfy this requirement unless the commissioner (director, superintendent) directs that additional or more recent financial information is required for the proper administration of this act;
 - (h) A description of the proposed method of marketing, a financial plan which includes a projection of operating results anticipated until the organization has had net income for at least one year, and a statement as to the sources of working capital as well as any other sources of funding;
 - (i) A power of attorney duly executed by such applicant, if not domiciled in this State, appointing the commissioner (director, superintendent) and his successors in office, and duly authorized deputies, as the true and lawful attorney of such applicant in and for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this State may be served;
 - (j) * A statement reasonably describing the geographic area or areas to be served;

*Editor's Note: Amended in 1974 by deleting the word "state" the phrase "nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health maintenance organization." See 1974 NAIC Proceedings (413).

- (k) A description of the complaint procedures to be utilized as required under Section 11;
 - (l) A description of the procedures and programs to be implemented to meet the quality of health care requirements in Section 4(1)(b);
 - (m) A description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under Section 6(2);
 - (n) Such other information as the commissioner (director, superintendent) may require to make the determinations required in Section 4.
- (4) (a) An applicant or a health maintenance organization holding a certificate of authority granted hereunder shall, unless otherwise provided for in this Act, file a notice describing any material modification of the operation set out in the information required by Subsection (3). Such notice shall be filed with the commissioner (director, superintendent) prior to the modification. If the commissioner (director, superintendent) does not disapprove within (insert number) days of filing, such modification shall be deemed approved.
- (b) The commissioner (director, superintendent) may promulgate rules and regulations exempting from the filing requirements of Paragraph (a) those items he deems unnecessary;
- (5) An applicant or a health maintenance organization holding a certificate of authority granted hereunder shall file all contracts of reinsurance. Any agreement between the organization and an insurer shall be subject to the laws of this state regarding reinsurance. All reinsurance agreements and any modifications thereto must be filed and approved. Reinsurance agreements shall remain in full force and effect for at least ninety (90) days following written notice by registered mail of cancellation by either party to the commissioner (director, superintendent).

Comment. Section 3 requires the licensing of an HMO in order to provide health care services on a prepaid basis. The legal entity, in which the responsibilities imposed by this Act are vested, serves as the focus of regulatory attention to assure that the consuming public is well served.

Subsection (1) is intended to provide a general override to existing state laws which restrict or prevent the formation or operation of health maintenance organizations. Among other restrictions, existing state laws may:

- (1) require approval of a health maintenance organization by a medical society;
- (2) require that physicians constitute all or a majority of the governing body of a health maintenance organization;
- (3) require that all physicians or a percentage of physicians in the local medical society be permitted to participate in rendering the services of the organization;
- (4) require that such organization submit to regulation as an insurer of health care services;
- (5) require that only unincorporated individuals or associations or partnerships may provide health care services;
- (6) prohibit advertising by a professional group for recruitment of enrollees.

In addition to the general override provided in Subsection (1), Section 25 specifically provides that the insurance law, the hospital and medical service corporation law and certain other provisions do not apply to HMO's. Furthermore, Section 6 specifically provides that any persons, whether or not providers of health care services, may serve on the governing body. There is no statutory requirement as to the appropriate composition of the membership of the governing body.

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It is assumed that, restrictive provisions of state law having been overcome, the "person" making application for a certificate of authority, if not an individual, will be created through existing state mechanisms such as the applicable non-profit corporation act, business corporation act, etc. as appropriate. Since state laws generally establish detailed procedures related to business organizations, inclusion of organizational procedures in a model Act of this nature would appear unnecessary. A business having incorporated under the law of a foreign state could qualify under this act after following appropriate state procedures required of foreign corporations seeking to do business in the state.

No provision for the organization of a health maintenance organization has been included in the model act. As is indicated in the health maintenance organization definition, any person—i.e. any natural or any artificial person created under the law of the particular state—may function as a health maintenance organization, subject to the licensing and regulatory provisions of the model act.

Section 4. Issuance of Certificate of Authority.

- (1) (a) Upon receipt of an application for issuance of a certificate of authority, the commissioner (director, superintendent) shall forthwith transmit copies of such application and accompanying documents to the (commissioner of public health).
 - (b) The (commissioner of public health) shall determine whether the applicant for a certificate of authority, with respect to health care services to be furnished:
 - (i) Has demonstrated the willingness and potential ability to assure that such health care services will be provided in a manner to assure both availability and accessibility of adequate personnel and facilities and in a manner enhancing availability, accessibility and continuity of service;
 - (ii) Has arrangements, established in accordance with the regulations promulgated by the (commissioner of public health) for an on-going quality assurance program concerning health care processes and outcomes; and
 - (iii) Has a procedure, established in accordance with regulations of the (commissioner of public health), to develop, compile, evaluate, and report statistics relating to the cost of its operations, the pattern of utilization of its services, the availability and accessibility of its services, and such other matters as may be reasonably required, by the (commissioner of public health).
 - (c) Within (insert number) days of receipt of the application for issuance of a certificate of authority, the (commissioner of public health) shall certify to the commissioner (director, superintendent) that the proposed health maintenance organization meets the requirements of Paragraph (b) or notify the commissioner (director, superintendent) that the health maintenance organization does not meet such requirements and specify in what respects it is deficient.
- (2) The commissioner (director, superintendent) shall issue or deny a certificate of authority to any person filing an application pursuant to Section 3 within (insert number) days of receipt of the certification from the (commissioner of public health). Issuance of a certificate of authority shall be granted upon payment of the application fee prescribed in Section 22 if the commissioner (director, superintendent) is satisfied that the following conditions are met:
 - (a) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy and possess good reputations;
 - (b) The (commissioner of public health) certifies, in accordance with Subsection (1), that the health maintenance organization's proposed plan of operation meets the requirements of Subsection (1)(b);

- (c) The health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for co-payments;
 - (d) The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner (director, superintendent) may consider:
 - (i) The financial soundness of the arrangements for health care services and the schedule of charges used in connection therewith;
 - (ii) The adequacy of working capital;
 - (iii) Any agreement with an insurer, a (hospital or medical service corporation), a government, or any other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the health maintenance organization;
 - (iv) Any agreement with providers for the provision of health care services; and
 - (v) Any deposit of cash or securities submitted in accordance with Section 13.
 - (e) The enrollees will be afforded an opportunity to participate in matters of policy and operation pursuant to Section 6;
 - (f) Nothing in the proposed method of operation, as shown by the information submitted pursuant to Section 3 or by independent investigation, is contrary to the public interest; and
 - (g) Any deficiencies identified by the (commissioner of public health) have been corrected.
- i) A certificate of authority shall be denied only after compliance with the requirements of Section 21.

Comment. A health maintenance organization combines several characteristics of an insurance operation (including the need for financial responsibility, the assumption of risk and similarity in marketing activities) with the characteristics of a health care delivery system. Section 4 provides for the authorization and regulation of health maintenance organizations to be carried out through existing state agencies. The creation of a new agency specifically for health maintenance organizations would unnecessarily duplicate existing functions in the state insurance and health departments. It is felt that the expertise of the state insurance department on fiscal and other regulatory matters and the familiarity of the state health department with regard to health matters should both be utilized in the regulation of health maintenance organizations. To minimize administrative problems, the prime responsibility for administration is vested in one agency—the insurance department. However, to the extent possible, the responsibilities of the two agencies are clearly defined with the insurance commissioner obligated to rely on the health department with respect to the latter's sphere of expertise.

Subsection (1)(b) empowers the commissioner of public health to establish and apply standards of quality concerning health care. Among the arguments raised against quality control are: (1) they may limit the number of HMO's which will get started, (2) quality assurance procedures will prove to be expensive and (3) such controls will engender opposition from certain providers. On the other hand, existing methods for quality control are said to be fragmented and inadequate. If the states are to authorize and encourage HMO's by this legislation, they have an obligation to assure that the health care services provided are of reasonable quality. This is particularly true because of the built-in incentive for an HMO to restrict the utilization of services due to the incentives to stay within a fixed budget.

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Subsection (1)(b)(i) is intended to require the HMO to define and set standards for the availability and accessibility of health care services which are adequate for the population which it intends to serve. Among other things, consideration might be given to whether there are enough physicians to provide the promised services and whether the services are available at convenient locations and hours. Subsection (1)(b)(ii) focuses responsibility upon the HMO to implement quality control as to processes and results to the extent that such concepts are developed into workable form. Such a program would require an assessment or monitoring of the processes used and the results achieved. For example, peer group and utilization review might be required. It is recognized that monitoring techniques concerning quality of health care are in their early stage of development. Nevertheless, this Subsection is drafted to authorize the use of more sophisticated monitoring techniques as they are developed and perfected. An HMO, being a system with a defined population and providers, is in the best position to identify problems and implement remedies. It is anticipated that in meeting these requirements, the HMO will have a person or a committee to serve as the focus of responsibility to assure quality care. Subsection (1)(b)(iii) requires the disclosure of information which, among other things, will provide comparative data among HMO's. This provides an incentive against negatively deviating from the norm. It also affords enrollees information to assist them in participating in the operation of the HMO as required in Section 6.

Subsection (2)(c) makes explicit the requirement that an HMO must provide a minimum package of services on a prepaid basis. Reasonable co-payments, however, are permitted and do not violate the requirement for prepayment. Such co-payments may be used to (a) reduce the amount of prepayments and (b) minimize frivolous utilization of services. In addition, an HMO may have more than one benefit package involving different levels of co-payments.

Under Subsection (2)(d), to grant a certificate of authority, the commissioner should be satisfied that the health maintenance organization will have the financial resources to provide the health care services for which it is obligated to its enrollees. However, it is recognized that requiring an HMO to have more than a minimum capitalization as set forth in Subsection 13(8) might prevent the organization or implementation of an otherwise viable HMO. Furthermore, with various possible insurance and surety arrangements available to back up the HMO's promise of performance, reserve requirements such as those found in the insurance laws are not deemed necessary.

Section 5. Powers of Health Maintenance Organizations.

- (1) The powers of a health maintenance organization include, but are not limited to the following:
 - (a) The purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and such property as may reasonably be required for its principal office or for such purposes as may be necessary in the transaction of the business of the organization.
 - (b) The making of loans to a medical group under contract with it in furtherance of its program or the making of loans to a corporation or corporations under its control for the purpose of acquiring or constructing medical facilities and hospitals or in furtherance of a program providing health care services to enrollees.
 - (c) The furnishing of health care services through providers which are under contract with or employed by the health maintenance organization.
 - (d) The contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment and administration.
 - (e) The contracting with an insurance company licensed in this State, or with a (hospital or medical service corporation) authorized to do business in this State, for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization.
 - (f) The offering of other health care services, in addition to basic health care services.

- (2) (a) A health maintenance organization shall file notice, with adequate supporting information, with the commissioner (director, superintendent) prior to the exercise of any power granted in Subsections (1)(a), (b) or (d). The commissioner (director, superintendent) shall disapprove such exercise of power only if in his opinion it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the commissioner (director, superintendent) does not disapprove within (insert number) days of the filing, it shall be deemed approved.
- (b) The commissioner (director, superintendent) may promulgate rules and regulations exempting from the filing requirement of Paragraph (a) those activities having a de minimis effect.

Comment: The exercise of authority granted in Subsections (1)(a), (1)(b) and (1)(d) shall be subject to disapproval by the commissioner within (insert number) days of a filing by a health maintenance organization. The commissioner may promulgate rules and regulations exempting certain contracts from the filing requirement where exercise of the authority granted in the section would have little or no effect on the financial condition and ability to meet obligations of the organization.

Section 6. Governing Body.

- (1) The governing body of any health maintenance organization may include providers, or other individuals, or both.
- (2) Such governing body shall establish a mechanism to afford the enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of other mechanisms.

Comment: While Section 3(1) should adequately override restrictive laws related to membership of a governing body, Section 6(1) makes explicit the permissible membership of such a group. The model bill does not, however, require that a health maintenance organization be consumer controlled. It is expected that HMO's controlled in a variety of ways will be organized. Where organizations are not consumer controlled, it is believed that some means for enrollee participation should be provided. For example, such matters as availability, accessibility and continuity of health care services are factors which directly confront the consumers and in which they have a particular interest. The disclosure of information under other sections is also designed to assist the consumers.

Arguments against a role for the consumer include: (1) such participation is unnecessary and perhaps even harmful to the efficient and professional delivery of health care services, (2) a consumer role will impede the initiation of an HMO since more people must be involved and (3) consumers can always seek alternative health care. The arguments for a consumer role seem more persuasive. These include (1) consumer participation results in a more responsive organization, and (2) consumer participation is not the same as lay control over the rendering of professional service.

Section 7. Fiduciary Responsibilities.

- (1) Any director, officer, employee or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of such organization shall be responsible for such funds in a fiduciary relationship to the organization.
- (2) A health maintenance organization shall maintain in force a fidelity bond on employees and officers in an amount not less than \$100,000 or such other sum as may be prescribed by the commissioner (director, superintendent). All such bonds shall be written with at least a one-year discovery period and if written with less than a three-year discovery period shall contain a provision that no cancellation or termination of the bond, whether by or at the request of the insured or by the underwriter, shall take effect prior to the expiration of 90 days after written notice of such cancellation or termination has been filed with the commissioner (director, superintendent) unless an earlier date of such cancellation or termination is approved by the commissioner (director, superintendent).

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Comment. As an optional additional subsection, language may be included that would make the appropriate provisions of the state's insurance laws governing prohibitions or restrictions on activities of directors, officers and certain shareholders applicable to health maintenance organizations.

Section 8. Evidence of Coverage and Charges for Health Care Services.

- (1) (a) Every enrollee residing in this state is entitled to an evidence of coverage. If the enrollee obtains coverage through an insurance policy or a contract issued by a (hospital or medical service corporation), whether by option or otherwise, the insurer or the (hospital or medical service corporation) shall issue the evidence of coverage. Otherwise, the health maintenance organization shall issue the evidence of coverage.
 - (b) No evidence of coverage, or amendment thereto, shall be issued or delivered to any person in this state until a copy of the form of the evidence of coverage, or amendment thereto, has been filed with and approved by the commissioner (director, superintendent).
 - (c) An evidence of coverage shall contain:
 - (i) No provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, which encourage misrepresentation, or which are untrue, misleading or deceptive as defined in Section 14(1); and
 - (ii) A clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:
 - (A) The health care services and the insurance or other benefits, if any, to which the enrollee is entitled;
 - (B) Any limitations on the services, kind of services, benefits, or kind of benefits, to be provided, including any deductible or co-payment feature;
 - (C) Where and in what manner information is available as to how services may be obtained;
 - (D) The total amount of payment for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts; and
 - (E) A clear and understandable description of the health maintenance organization's method for resolving enrollee complaints.
- Any subsequent change may be evidenced in a separate document issued to the enrollee.
- (d) A copy of the form of the evidence of coverage to be used in this State, and any amendment thereto, shall be subject to the filing and approval requirements of Paragraph (b) unless it is subject to the jurisdiction of the commissioner (director, superintendent) under the laws governing health insurance or (hospital or medical service corporations) in which event the filing and approval provisions of such laws shall apply. To the extent, however, that such provisions do not apply to the requirements in Paragraph (c), the requirements in Paragraph (c) shall be applicable.
 - (2) (a) No schedule of charges for enrollee coverage for health care services, or amendment thereto, may be used until a copy of such schedule, or amendment thereto, has been filed with and approved by the commissioner (director, superintendent).

- (b) Such charges may be established in accordance with actuarial principles for various categories of enrollees, provided that charges applicable to an enrollee shall not be individually determined based on the status of his health. However, the charges shall not be excessive, inadequate, or unfairly discriminatory. A certification, by a qualified actuary or other qualified person acceptable to the commissioner (director, superintendent), to the appropriateness of the use of the charges, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.
- (3) The commissioner (director, superintendent) shall within a reasonable period, approve any form if the requirements of Subsection (1) are met and any schedule of charges if the requirements of Subsection (2) are met. It shall be unlawful to issue such form or to use such schedule or charges until approved. If the commissioner (director, superintendent) disapproves such filing, he shall notify the filer. In the notice, the commissioner (director, superintendent) shall specify the reasons for his disapproval. A hearing will be granted within (insert number) days after a request in writing by the person filing. If the commissioner (director, superintendent) does not approve any form or schedule of charges within (insert number) days of the filing of such forms or charges, they shall be deemed approved.
- (4) The commissioner (director, superintendent) may require the submission of whatever relevant information he deems necessary in determining whether to approve or disapprove a filing made pursuant to this Section.

Comment: Subsection (1)(a) requires that every enrollee be provided with evidence of coverage and allocates the responsibility for providing that evidence. Paragraph (c) establishes requirements which such evidence of coverage must meet. The group contracts to be filed pursuant to Section 3(3)(f) are not subject to the standards and filing requirements of Section 8, since such group contracts are not issued to enrollees. Paragraph (d) clarifies the relationship between filing requirements under this Section and under the state insurance or hospital or medical service corporation law. Filing is required under Paragraph (b) unless the form is already subject to filing requirements under existing state law. However, where existing state law does not apply standards as strict as those contained in Paragraph (c), such standards are, in effect, read into the existing law. Where the filing under state insurance or medical or hospital service corporation law is required to meet standards as strict as those in Paragraph (c), the former would be applicable. A state may want Paragraph (d) to be revised to make specific reference to existing state laws.

Subsection (2)(a) provides for the filing of charges for health care services, i.e., that part of the benefit package which is provided in the form of service vis-a-vis indemnity or service benefits. Those parts of the package providing benefits under agreement with an insurance company or hospital or medical service corporation will be subject to regulation in accordance with existing laws.

Paragraph (b) neither requires nor prohibits community rating. Reasonable underwriting classifications are permitted for the purpose of establishing the charges. Different charges may be imposed on different groups of enrollees. Such a rigid requirement as community rating would appear to be inappropriate when the competing financing mechanisms are not subject to such a constraint. The competitive disadvantage which such requirement might impose could impede the development of HMO's.

Because of its somewhat different nature, an HMO is not required by this Act to meet reserve requirements similar to those imposed on insurance companies. Thus it is important that the charges be set at an adequate level. The requirement for certification by an actuary or other qualified person along with supporting information is intended to assist the commissioner in determining adequacy. In applying the standard of excessive, inadequate, or unfairly discriminatory, it is contemplated that the commissioner may consider the amount necessary to assure a reasonable return on the initial and subsequent capital invested and an amount needed to accumulate adequate funds to stabilize the level of charges against fluctuation due to inflation, changes in medical technology and related causes.

Section 9. Annual Report.

- (1) Every health maintenance organization shall annually, on or before the first day of March, file a report verified by at least two principal officers with the commissioner (director, superintendent), with a copy to the (commissioner of public health) covering the preceding calendar year. Such report shall be on forms prescribed by the commissioner (director, superintendent).
- (2) The commissioner (director, superintendent) may require such additional reports as are deemed reasonably necessary and appropriate to enable the commissioner (director, superintendent) to carry out his duties under this act.

Comment. This section provides the commissioner with the authority to require reports considered necessary to carry out his duties. The reports could include:

A financial statement of the organization;

Any material changes in the information submitted pursuant to Section 3(3);

The number of persons enrolled at the beginning and end of the year;

A summary of information compiled pursuant to Section 4(1)(b)(iii); and

The amount of uncovered and covered expenditures that are payable and more than 90 days past due.

In establishing filing requirements the commissioner (director, superintendent) should be cognizant of the fact that HMO's that are qualified under the federal HMO Act must submit detailed reports to the Department of Health and Human Services. The commissioner (director, superintendent) should make use of such reports when they are relevant and avoid the imposition of duplicate reporting requirements.

Section 10. Information to Enrollees.

Every health maintenance organization shall provide promptly to its enrollees notice of any material change in the operation of the organization that will affect them directly.

Section 11. Complaint System.

- (1) (a) Every health maintenance organization shall establish and maintain a complaint system which has been approved by the commissioner (director, superintendent), after consultation with the (commissioner of public health), to provide reasonable procedures for the resolution of written complaints initiated by enrollees.
- (b) Each health maintenance organization shall submit to the commissioner (director, superintendent) and the (commissioner of public health) an annual report in a form prescribed by the commissioner (director, superintendent), after consultation with the (commissioner of public health), which shall include:
 - (i) A description of the procedures of such complaint system;
 - (ii) The total number of complaints handled through such complaint system and a compilation of causes underlying the complaints filed; and
 - (iii) The number, amount, and disposition of malpractice claims made by an enrollee of the organization that were settled during the year by the health maintenance organization. All such information shall be held in confidence by the commissioner (director, superintendent).
- (2) The commissioner (director, superintendent) or the (commissioner of public health) may examine such complaint system.

Comment: Every health maintenance organization is required to establish a complaint system to provide reasonable procedures for the disposition of complaints. The organizations may be expected to receive two types of complaints. One type is related to the basic health care services or additional services furnished by it. The other type is related to that portion of the coverage in addition to basic health care services which is provided by insurance, hospital or medical service corporations, or some means other than being furnished by the organization. For complaints arising from health care services, the administrative procedure to handle complaints should provide the mechanism through which enrollees receive a fair and proper opportunity to have their cases heard, including the use of binding arbitration as a means of resolving claims concerning coverage. For complaints regarding benefits over which the health maintenance organization has no direct control such as those portions of the benefit package which are covered by insurance, the health maintenance organization is responsible only for maintaining statistical information and transmitting the complaints to the persons responsible.

In establishing the format for records and reports pursuant to this Section, the commissioner may want to require disclosure similar to that provided for under the NAIC Model Unfair Trade Practices Act. Section 4(10) of that Act requires, among other data, a record of total number of complaints since the last examination, the nature of each complaint, the disposition of the complaint, and the time it took to process each complaint. (See 1972 NAIC Proceedings I 443).

Section 12. Investments.

With the exception of investments made in accordance with Section 5(1)(a) and (b) and Section 5(2), the funds of a health maintenance organization shall be invested only in securities or other investments permitted by the laws of this State for the investment of assets constituting the legal reserves of life insurance companies or such other securities or investments as the commissioner (director, superintendent) may permit.

Comment: Life and health insurers are subject to statutory investment requirements designed to assure conservatism and liquidity in the handling of the insurer's funds. Sound financial management is an important element in the variable operation of an HMO. Furthermore, it is contrary to the intent of this bill to foster conditions which would enable an HMO to be used as a "front" for a speculative investment operation. At the same time, however, it is recognized that for an HMO to fulfill its expected functions, it may be both desirable and necessary for the HMO to invest a portion of its capital funds in facilities and services to better enable it to meet its obligations. Such investments may not conform to the traditional insurance law investment limitations. Consequently, this section excepts this type of investment when approved by the commissioner in accordance with the standards set out in Section 5(2).

Section 13. Protection Against Insolvency.

- (1) Unless otherwise provided below, each health maintenance organization shall deposit with the commissioner (director, superintendent) or with any organization or trustee acceptable to him through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that is acceptable to him in the amount set forth in this section.
- (2) The amount for an organization that is beginning operation shall be the greater of: (a) five percent (5%) of its estimated expenditures for health care services for its first year of operation, (b) twice its estimated average monthly uncovered expenditures for its first year of operation or (c) \$100,000.

At the beginning of each succeeding year, unless not applicable, the organization shall deposit with the commissioner (director, superintendent) or organization or trustee, cash, securities, or any combination of these or other measures acceptable to the commissioner (director, superintendent), in an amount equal to four percent (4%) of its estimated annual uncovered expenditures for that year.

- (3) Unless not applicable, an organization that is in operation on the effective date of this section shall make a deposit equal to the larger of: (a) one percent (1%) of the preceding 12 months uncovered expenditures, or (b) \$100,000 on the first day of the fiscal year beginning six (6) months or more after the effective date of this section.

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In the second fiscal year, if applicable, the amount of the additional deposit shall be equal to two percent (2%) of its estimated annual uncovered expenditures. In the third fiscal year, if applicable, the additional deposit shall be equal to three percent (3%) of its estimated annual uncovered expenditures for that year, and in the fourth fiscal year and subsequent years, if applicable, the additional deposit shall be equal to four percent (4%) of its estimated annual uncovered expenditures for each year. Each year's estimate, after the first year of operation shall reasonably reflect the prior year's operating experience and delivery arrangements.

- (4) The commissioner (director, superintendent) may waive any of the deposit requirements set forth in subsection (1) and (2) above whenever satisfied that the organization has sufficient net worth and an adequate history of generating net income to assure its financial viability for the next year, or its performance and obligations are guaranteed by an organization with sufficient net worth and an adequate history of generating net income, or the assets of the organization or its contracts with insurers, (hospital or medical service corporations), governments, or other organizations are reasonably sufficient to assure the performance of its obligations.
- (5) When an organization has achieved a net worth not including land, buildings, and equipment of at least \$1 million or has achieved a net worth including organization-related land, buildings, and equipment of at least \$5 million, the annual deposit requirement shall not apply.

The annual deposit requirement shall not apply to an organization if the total amount of the accumulated deposit is equal to 25% of its estimated annual uncovered expenditures for the next calendar year, or the capital and surplus requirements for the formation for admittance of an accident and health insurer in this state, whichever is less.

If the organization has a guaranteeing organization which has been in operation for at least five (5) years and has a net worth not including land, buildings and equipment of at least \$1 million or which has been in operation for at least ten (10) years and has a net worth including organization-related land, buildings, and equipment of at least \$5 million, the annual deposit requirement shall not apply; provided, however, that if the guaranteeing organization is sponsoring more than one organization, the net worth requirement shall be increased by a multiple equal to the number of such organizations. This requirement to maintain a deposit in excess of the deposit required of an accident and health insurer shall not apply during any time that the guaranteeing organization maintains for each organization it sponsors a net worth at least equal to the capital and surplus requirements for an accident and health insurer.

- (6) All income from deposits shall belong to the depositing organization and shall be paid to it as it becomes available. A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities, or any combination of these or other measures of equal amount and value. Any securities shall be approved by the commissioner (director, superintendent) before being substituted.
- (7) In any year in which an annual deposit is not required of an organization, at the organization's request the commissioner shall reduce the required, previously accumulated deposit by \$100,000 for each \$250,000 of net worth in excess of the amount that allows the organization not to make the annual deposit. If the amount of net worth no longer supports a reduction of its required deposit, the organization shall immediately redeposit \$100,000 for each \$250,000 of reduction in net worth, provided that its total deposit shall not exceed the maximum required under this section.
- (8) Each health maintenance organization that obtains a certificate of authority after the effective date of this subsection shall have and maintain a capital account of at least \$100,000 in addition to any deposit requirements under this Section. The capital account shall be net of any accrued liabilities and be in the form of cash, securities or any combination of these or other measures acceptable to the commissioner (director, superintendent).

Comment. Even though very serious problems can arise if a health maintenance organization defaults on its contracts, fiscal control of health maintenance organizations in a manner comparable to that applied to insurance companies appears inappropriate in view of the service nature of such organizations. The best protection for enrollees is a financially sound organization that generates net income. However, beginning health maintenance organizations are often small businesses with limited financial resources that will sustain operating losses in their early years. Unreasonably high starting capital or reserve requirements may prevent some organization from starting or may unreasonably tie up the capital of those that do. Therefore, this Section provides for a structured but flexible approach to protecting against insolvency. It requires the maintenance of a minimum capital account, a deposit of cash or securities in a minimum account, and the organization's generation of additional amounts annually as a source of funds to meet its contractual obligations to the enrollees in the event of insolvency. The commissioner may waive all or part of these requirements when satisfied that the organization has sufficient net worth or an adequate history of generating net income to assure its viability. The requirements may also be waived if the health maintenance organization's performance is guaranteed by another financially strong organization.

The section relates the deposit requirements to the amount of the health maintenance organization's uncovered expenditures. This amount will vary depending upon the type of organization and the nature of its arrangements with providers. For example, the physicians of the staff of the organization or a contracting medical group or individual practice association may agree to look only to the organization for payment of services provided to the organization's enrollees and agree not to bill them in the event of insolvency.* An organization could have insurance for all or part of its hospitalization expense or another organization could agree to guarantee that the liabilities of the health maintenance organization are met.

In all such cases, it is recommended that the contractual provision require the provider or guarantor to notify the commissioner if the provision or insurance is modified or no longer in effect or if payment on the contract or policy has not been made in a reasonable period of time. (Section 3(5) requires prior notification of cancellation of any reinsurance.) This can provide an early warning of possible adverse changes in the health maintenance organization's financial position. In addition, the status of such provisions or policies should be covered in annual interrogatories to the organization.

The requirement in Subsection (8) for a capital account only applies to organizations licensed after the effective date of the subsection. Thus, the capital account requirement would have to be taken into consideration by persons starting a new HMO. If a state wishes to apply the requirement to existing HMO's, it should allow for an appropriate phase-in period.

It is believed that these provisions and the related provisions of Section 4(2)(d), including possible insurance backup arrangements, provide adequate assurances. The failure to provide assurances as required would subject the health maintenance organization to suspension or revocation of its certificate of authority under Section 18.

Section 14. Prohibited Practices.

- (1) No health maintenance organization, or representative thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For purposes of this act:
 - (a) A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment with a health maintenance organization;

*A Provision to accomplish this might read:

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ABC Medical Group and its physicians will look solely to XYZ HMO for compensation for medical services and other services incident thereto rendered by ABC Medical Group to enrollees of XYZ HMO, and will not assert any claim for compensation (other than collection of supplemental charges on XYZ HMO's behalf) against enrollees of XYZ HMO for medical services in the event of non payment by XYZ HMO. Any modification or deletion of this provision shall be reported within 15 days to the state commissioner of insurance.

- (b) A statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which such statement is made or such item of information is communicated, such statement or item of information may be reasonably understood by a reasonable person, not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation, or disadvantage of possible significance to an enrollee of, or person considering enrollment in a health maintenance organization if such benefit or advantage or absence of limitation, exclusion or disadvantage does not in fact exist;
- (c) An evidence of coverage shall be deemed to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge regarding health maintenance organizations and evidences of coverage therefor, to expect benefits, services, charges, or other advantages which the evidence of coverage does not provide or which the health maintenance organization issuing such evidence of coverage does not regularly make available for enrollees covered under such evidence of coverage.
- (2) Sections (cite state code sections affecting unfair trade practices) shall be construed to apply to health maintenance organizations and evidences of coverage except to the extent that the commissioner (director, superintendent) determines that the nature of health maintenance organizations and evidences of coverage render such sections clearly inappropriate.
- (3) A health maintenance organization may not cancel or refuse to review an enrollee, except for reasons stated in the organization's rules applicable to all enrollees, or for the failure to pay the charge for such coverage, or for such other reasons as may be promulgated by the commissioner (director, superintendent).
- (4) No health maintenance organization unless licensed as an insurer may refer to itself as an insurer or use a name deceptively similar to the name or description of any insurance or surety corporation doing business in the State.
- (5) Any person not in possession of a valid certificate of authority issued pursuant to this Act may not use the phrase "health maintenance organization" or "HMO" in the course of operation.

Comment: Subsection (3) is designed to foster continuance of coverage to the extent possible. However, depending on the circumstances in a given state, some exceptions may be necessary. Such exceptions might include termination of employment, termination of the group plan, enrollee moving out of the area served, enrollee moving out of an eligible class, failure to make reasonable co-payment, refusal to accept services, enrollee misrepresentation on application, allowing a non-enrollee to use an HMO identification card to receive services, or failure to maintain a satisfactory physician-patient relationship.

Section 15. Regulation of Agents.

- (1) The commissioner (director, superintendent) may, after notice and hearing, promulgate such reasonable rules and regulations as are necessary to provide for the licensing of agents. An agent means a person who is appointed or employed by a health maintenance organization and who engages in solicitation of membership in such organization. This definition does not include a person enrolling members on behalf of an employer, union or other organization to whom a master subscriber contract has been issued.

- (2) The commissioner (director, superintendent) may by rule exempt certain classes of persons from the requirement of obtaining a license:
 - (a) If the functions they perform do not require special competence, trustworthiness or the regulatory surveillance made possible by licensing; or
 - (b) If other existing safeguards make regulation unnecessary.

Section 16. Powers of Insurers and (Hospital and Medical Service Corporations).

- (1) An insurance company licensed in this state, or a (hospital or medical service corporation) authorized to do business in this State, may either directly or through a subsidiary or affiliate organize and operate a health maintenance organization under the provisions of this act. Notwithstanding any other law which may be inconsistent herewith, any two or more such insurance companies, (hospitals or medical service corporations), or subsidiaries or affiliates thereof, may jointly organize and operate a health maintenance organization. The business of insurance is deemed to include the providing of health care by a health maintenance organization owned or operated by an insurer or a subsidiary thereof.
- (2) Notwithstanding any provision of insurance and (hospital or medical service corporation) laws (citations), an insurer or a (hospital or medical service corporation) may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations.

The enrollees of a health maintenance organization constitute a permissible group under such laws. Among other things, under such contracts, the insurer or (hospital or medical service corporation) may make benefit payments to health maintenance organizations for health care services rendered by providers.

Comment: Subsection (2) overrides the group laws to permit an insurer or a hospital or medical service corporation to provide coverage protecting enrollees of an HMO. This authority is intended to permit insurers and the service corporations to write coverage (1) to fill the gaps which the providers of health care services do not provide, (2) to provide coverage in excess of the services provided, (3) to cover catastrophe situations, (4) to provide protection to the enrollees in the event the HMO becomes insolvent, and (5) to provide coverage against the cost of health care services as the health maintenance organization deems necessary. This section might also be redrafted to make specific reference to the relevant Section of existing law.

Section 17. Examination.

- (1) The commissioner (director, superintendent) may make an examination of the affairs of any health maintenance organization and providers with whom such organization has contracts, agreements, or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this State but not less frequently than once every three years.
- (2) The (commissioner of public health) may make an examination concerning the quality of health care service of any health maintenance organization and providers with whom such organization has contracts, agreements, or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this State but not less frequently than once every three years.
- (3) Every health maintenance organization and provider shall submit its relevant books and records for such examinations and in every way facilitate them. For the purpose of examinations, the commissioner (director, superintendent) and the (commissioner of public health) may administer oaths to, and examine the officers and agents of the health maintenance organization and the principals of such providers concerning their business.

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- (4) The expenses of examinations under this Section shall be assessed against the organization being examined and remitted to the commissioner (director, superintendent) or the (commissioner of public health) for whom the examination is being conducted.
- (5) In lieu of such examination, the commissioner (director, superintendent) or (commissioner of public health) may accept the report of an examination made by the commissioner (director, superintendent) or (commissioner of public health) of another state.

Comment: The commissioner is provided authority to examine health maintenance organizations as is reasonably necessary. However, any determination related to the quality of health care services is the exclusive responsibility of the commissioner of public health. A state may wish to include in this section an incorporation by reference of the relevant statutory examination sections that apply to insurers.

Section 18. Suspension or Revocation of Certificate of Authority.

- (1) The commissioner (director, superintendent) may suspend or revoke any certificate of authority issued to a health maintenance organization under this act if he finds that any of the following conditions exist:
 - (a) The health maintenance organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted under Section 3, unless amendments to such submissions have been filed with and approved by the commissioner (director, superintendent);
 - (b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of Section 8;
 - (c) The health maintenance organization does not provide or arrange for basic health care services;
 - (d) The (commissioner of public health) certifies to the commissioner (director, superintendent) that:
 - (i) The health maintenance organization does not meet the requirements of Section 4(1)(b); or
 - (ii) The health maintenance organization is unable to fulfill its obligations to furnish health care services.
 - (e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;
 - (f) The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under Section 6.
 - (g) The health maintenance organization has failed to implement the complaint system required by Section II in a reasonable manner to resolve valid complaints;
 - (h) The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;
 - (i) The continued operation of the health maintenance organization would be hazardous to its enrollees;
 - (j) The health maintenance organization has otherwise failed substantially to comply with this act.

- (2) A certificate of authority shall be suspended or revoked only after compliance with the requirements of Section 21.
- (3) When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of such suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation whatsoever.
- (4) When the certificate of authority of a health maintenance organization is revoked, such organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner (director, superintendent) may, by written order, permit such further operation of the organization as he may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

Section 19. Rehabilitation, Liquidation, or Conservation of a Health Maintenance Organization.

- (1) Any rehabilitation, liquidation or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation, or conservation of an insurance company and shall be conducted under the supervision of the commissioner (director, superintendent) pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies. The commissioner (director, superintendent) may apply for an order directing him to rehabilitate, liquidate, or conserve a health maintenance organization upon any one or more grounds set out in (cite sections of state rehabilitation law), or when in his opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state. Enrollees shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.
- (2) A claim by a health care provider for an uncovered expenditure has the same priority as an enrollee, provided such provider of services agrees not to assert such claim against any enrollee of the health maintenance organization.

Comment. Section 19 provides for the rehabilitation, liquidation, or conservation of health maintenance organizations to be carried out by the Commissioner under state laws applicable to insurance companies. Inasmuch as all states have existing authority, it is felt that the use of such statutes would be appropriate and would avoid the necessity of developing new administrative procedures applicable only to health maintenance organizations. Subsection (2) is designed to provide the maximum protection for enrollees by paying those providers that can bill the enrollee before those that have agreed not to. However, in order to obtain this priority, the provider must agree that the payment fully discharges the obligation of the enrollee. Incidentally, the NAIC has recommended the adoption of a model liquidation and rehabilitation act (See 1968 NAIC Proceedings I 214).

Section 20. Regulations.

The commissioner (director, superintendent) may, after notice and hearing, promulgate reasonable rules and regulations, as are necessary or proper to carry out the provisions of this Act. Such rules and regulations shall be subject to review in accordance with (insert section number providing for review of administrative orders).

Section 21. Administrative Procedures.

- (1) When the commissioner (director, superintendent) has cause to believe that grounds for the denial of an application for a certificate of authority exist, or that grounds for the suspension or revocation of a certificate of authority exist, he shall notify the health maintenance organization and the (commissioner of public health) in writing specifically stating the grounds for denial, suspension, or revocation and fixing a time of at least (insert number) days thereafter for a hearing on the matter.

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- (2) The (commissioner of public health), or his designated representative, shall be in attendance at the hearing and shall participate in the proceedings. The recommendation and findings of the (commissioner of public health) with respect to matters relating to the quality of health care services provided in connection with any decision regarding denial, suspension, or revocation of a certificate of authority, shall be conclusive and binding upon the commissioner (director, superintendent). After such hearing, or upon the failure of the health maintenance organization to appear at such hearing, the commissioner (director, superintendent) shall take action as is deemed advisable on written findings which shall be mailed to the health maintenance organization with a copy thereof to the (commissioner of public health). The action of the commissioner (director, superintendent) and the recommendation and findings of the (commissioner of public health) shall be subject to review by the (name of court of primary jurisdiction for claims of the nature and magnitude described) having jurisdiction. The court may, in disposing of the issue before it, modify, affirm, or reverse the order of the commissioner (director, superintendent) in whole or in part.
- (3) The provisions of the (Administrative Procedure Act) of this state shall apply to proceedings under this section to the extent they are not in conflict with Subsections (1).

Comment. This section provides an administrative framework within which action related to the denial, suspension, or revocation of any certificate of authority may be taken. Where a state has a comprehensive Administrative Procedure Act or other legislation providing appropriate procedural requirements, this section may be omitted.

Section 22. Fees.

- (1) Every health maintenance organization subject to this Act shall pay to the commissioner (director, superintendent) the following fees:
 - (a) For filing an application for a certificate of authority or amendment thereto, (insert amount) dollars;
 - (b) For filing an amendment to the organization documents that requires approval, (insert amount) dollars;
 - (c) For filing each annual report, (insert amount) dollars.
- (2) Fees charged under this section shall be distributed as follows: (insert dollar amount) to the commissioner (director, superintendent) and (insert dollar amount) to the (commissioner of public health).

Comment: Proper administration of the HMO program by the Departments of Insurance and Public Health will impose additional financial burdens on the respective departments. For this reason, it is appropriate to establish a fee system through which HMO's are required to bear the expenses associated with their regulation by the State. While provisions of some state laws require that income generated by fees be placed with general state revenues, the fees should not be looked upon as a general revenue producing device since such action might adversely affect the establishment of HMO's.

As an alternative to requiring fees with a filing of the annual report, a State might provide for a certificate renewal fee. In addition, or in lieu thereof, a state might consider a per capita enrollee tax or a tax on the charges made for health care services. Those parts of the health care plan provided by insurance will already be subject to a state's premium tax.

Inasmuch as the responsibility for the administration of the act is shared by the Departments of Insurance and Public Health, it would appear proper to provide for an equitable division of the fee income in those states where such receipts accrue to the collecting agencies and are not placed in the general revenue.

Section 23. Penalties and Enforcement.

- (1) The commissioner (director, superintendent) may, in lieu of suspension or revocation of a certificate of authority under Section 18, levy an administrative penalty in an amount not less than (insert amount) dollars nor more than (insert amount) dollars, if reasonable notice in writing is given of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation. The commissioner (director, superintendent) may augment this penalty by an amount equal to the sum that he calculates to be the damages suffered by enrollees or other members of the public.
- (2) (a) If the commissioner (director, superintendent) or the (commissioner of public health) shall for any reason have cause to believe that any violation of this act has occurred or is threatened, the commissioner (director, superintendent) or (commissioner of public health) may give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in such suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation, and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.
- (b) Proceedings under this subsection shall not be governed by any formal procedural requirements, and may be conducted in such manner as the commissioner (director, superintendent) or the (commissioner of public health) may deem appropriate under the circumstances. However, unless consented to by the health maintenance organization, no rule or order may result from a conference until the requirements of this section or Section 21 of this act are satisfied.
- (3) (a) The commissioner (director, superintendent) may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of this act.
- (b) Within (insert number) of days after service of the cease and desist order, the respondent may request a hearing on the question of whether acts or practices in violation of this Act have occurred. Such hearings shall be conducted pursuant to (cite Sections of State Administrative Procedure Act), and judicial review shall be available as provided by (cite sections of State Administrative Procedure Act).
- (4) In the case of any violation of the provisions of this act, if the commissioner (director, superintendent) elects not to issue a cease and desist order, or in the event of non-compliance with a cease and desist order issued pursuant to Subsection (3), the commissioner (director, superintendent) may institute a proceeding to obtain injunctive or other appropriate relief in the (name of court of primary jurisdiction for actions of this nature).

Comment: Sections 23(3) and 23(4) authorize the commissioner to issue a cease and desist order and to apply for injunctive relief. When the commissioner is not granted such statutory powers, the language should be modified to provide for the legal steps to be taken by the attorney general or other appropriate state official.

Section 24. Statutory Construction and Relationship to Other Laws.

- (1) Except as otherwise provided in this act, provisions of the insurance law and provisions of (hospital or medical service corporation) laws shall not be applicable to any health maintenance organization granted a certificate of authority under this act. This provision shall not apply to an insurer or (hospital or medical service corporation) licensed and regulated pursuant to the insurance law or the (hospital or medical service corporation) laws of this State except with respect to its health maintenance organization activities authorized and regulated pursuant to this act.

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- (2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.
- (3) Any health maintenance organization authorized under this act shall not be deemed to be practicing medicine and shall be exempt from the provision of (citation) relating to the practice of medicine.

Section 25. Filings and Reports as Public Documents.

All applications, filings and reports required under this act, except those which are trade secrets or privileged or confidential commercial or financial information, other than any annual financial statement that may be required under Section 9 of this act, shall be treated as public documents.

Section 26. Confidentiality of Medical Information.

Any data or information pertaining to the diagnosis, treatment, or health of any enrollee or applicant obtained from such person or from any provider by any health maintenance organization shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this act; or upon the express consent of the enrollee or applicant; or pursuant to statute or court order for the production of evidence or the discovery thereof; or in the event of claim or litigation between such person and the health maintenance organization wherein such data or information is pertinent. A health maintenance organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the health maintenance organization is entitled to claim.

Section 27. (Commissioner of Public Health's) Authority to Contract.

The (commissioner of public health), in carrying out his obligations under Sections 4(1)(b), 17(2), and 18(1), may contract with qualified persons to make recommendations concerning the determinations required to be made by him. Such recommendations may be accepted in full or in part by the (commissioner of public health).

Comment: This section authorizes the Department of Public Health to draw upon outside expertise where appropriate. One alternative would be to contract with Professional Standards Review Organizations established pursuant to Public Law 92-604.

Section 28. Acquisition of Control of or Merger of a Health Maintenance Organization.

No person may make a tender for or a request or invitation for tenders of, or enter into an agreement to exchange securities for or acquire in the open market or otherwise, any voting security of a health maintenance organization or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly, (or by conversion or by exercise of any right to acquire) be in control of the health maintenance organization, and no person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a health maintenance organization, unless, at the time any offer, request, or invitation is made or any agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the person has filed with the commissioner (director, superintendent) and has sent to the health maintenance organization, information required by section (cite Sections 3(b)(1)(i)(ii), (2) (3) (4) (5) (12) of the NAIC Model Insurance Holding Company System Regulatory Act) and the offer, request, invitation, agreement or acquisition has been approved by the commissioner (director, superintendent). Approval by the commissioner (director, superintendent) shall be governed by section (cite Section 3(d)(1) and (2) of the NAIC Model Insurance Holding Company System Regulatory Act).

Section 29. Dual Choice.

Each employer, public or private, in this state which offers its employees a health benefit plan and employs not less than twenty-five employees, and each employee benefit fund in this state which offers its members any form of health benefit, shall make available to and inform its employees or members of the option to enroll in at least one health maintenance organization holding a valid certificate of authority which provides health care services in the geographic areas in which a substantial number of such employees or members reside. Where there is a prevailing collective bargaining agreement, the selection of the health maintenance organization(s) to be made available to the employees shall be made under the agreement.

No employer in this state shall be required to pay more for health benefits as a result of the application of this section than would otherwise be required by any prevailing collective bargaining agreement or other contract for the provision of health benefits to its employees, provided that the employer or benefits fund shall pay to the health maintenance organization chosen by each employee or member an amount equal to the lesser of (a) the amount paid on behalf of its other employees or members for health benefits or (b) the health maintenance organization's charge for coverage approved by the commissioner (director, superintendent) pursuant to Section 8 of this act.

Comment: This Section is similar to Section 1310 of the federal HMO Act, but extends the dual choice requirement to state licensed HMO's. The licensing requirements of this act are less stringent than the federal requirements, so this provision will assist in the development and growth of state licensed HMO's.

Section 30. Severability.

If any section, term, or provision of this act shall be adjudged invalid for any reason, such judgment shall not affect, impair, or invalidate any other section, term, or provision of this act, but the remaining sections, terms and provisions shall be and remain in full force and effect.

Legislative History (all references are to the Proceedings of the NAIC).

1973 Proc. I 9, 11, 141, 192, 202-222 (adopted).

1973 Proc. II 139 (synopsis of model).

1974 Proc. I 12, 14, 405, 413 (amended).

1982 Proc. I 19, 28, 431, 498-499, 530-554 (revised and reprinted).

Model Regulation Service - April 1986

MODEL HEALTH MAINTENANCE ORGANIZATION ACT

The date in parentheses is the effective date of the legislation or regulation.

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Alabama	NO ACTION TO DATE	
Alaska	NO ACTION TO DATE	
Arizona		ARIZ. REV. STAT. ANN. §§ 20-1051 to 20-1069 (1973), entitled "Health Care Service Organizations".
Arkansas	ARK. STAT. ANN. §§ 66-5201 to 66-5228 (1975/1985).	
California	NO ACTION TO DATE	
Colorado	COLO. REV. STAT. §§ 10-17-101 to 10-17-133 (1963).	
Connecticut	NO ACTION TO DATE	
Delaware		DEL. CODE ANN. tit 16, §§ 9101 to 9118 (1982).
D.C.	NO ACTION TO DATE	
Florida		INS. COMM'R RULES, ch. 4-31 (1972).
Georgia		GA. CODE §§ 33-21-1 to 33-22-28 (1979) (Very similar to Model but many extra provisions).
Guam	NO ACTION TO DATE	
Hawaii	NO ACTION TO DATE	
Idaho		IDAHO REV. STAT. §§ 41-3901 to 41-3934 (1974 1985).
Illinois		ILL. REV. STAT. ch. 111 1 2, §§ 1401 to 1417 (1981 1986).

Model Regulation Service - April 1986

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Indiana	NO ACTION TO DATE	
Iowa		IOWA CODE ANN. §§ 514B.1 to 514B.32 (1973); see also REG. §§ 510-40.1 to 510-40.14 (1982).
Kansas		KAN. STAT. ANN. §§ 40-3201 to 40-3226 (1974).
Kentucky		KY. REV. STAT. §§ 304.38-010 to 304.38-210 (1982); see also KY. ADMIN. REGS. §§ 38:010 to 38:020 (1982).
Louisiana	NO ACTION TO DATE	
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 4201 to 4226 (1975).	
Maryland	NO ACTION TO DATE	
Massachusetts		MASS. GEN LAWS ANN. ch. 176G, §§ 1 to 17 (1976).
Michigan		MICH. COMP. LAWS. §§ 333.21001 to 333.21099 (1982).
Minnesota	MINN. STAT. §§ 62D.01 to 62D.30 (1973).	
Mississippi	NO ACTION TO DATE	
Missouri	MO. REV. STAT. §§ 354.400 to 354.550 (1983).	
Montana	NO ACTION TO DATE	
Nebraska	NEB. REV. STAT §§ 44-3201 to 44-3291 (1978).	
Nevada		NEV. REV. STAT. §§ 695C.010 to 695C.350 (1973).
New Hampshire		N.H. REV. STAT. ANN. §§ 420-B:1 to 420-B:22 (1977).

Model Regulation Service - April 1986

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
New Jersey	N.J. STAT. ANN. §§ 26:2J-1 to 26:2J-30 (1973).	
New Mexico	N.M. STAT. ANN. §§ 59A-46-1 to 59A-45-31 (1984).	
New York		N.Y. PUB. HEALTH LAW §§ 4400 to 4413 (1976).
North Carolina	N.C. GEN. STAT. §§ 57B-1 to 57B-25 (1979).	
North Dakota		N.D. CENT. CODE §§ 26.1-18-01 to 26.1-18-35 (1983).
Ohio		OHIO REV. STAT. ANN. §§ 1742.01 to 1742.33 (1976).
Oklahoma		OKLA. STAT. tit. 63, §§ 2501 to 2510 (1975).
Oregon	NO ACTION TO DATE	
Pennsylvania		PA. STAT. ANN. tit. 40, §§ 83-101 to 83-119 (1981).
Puerto Rico	NO ACTION TO DATE	
Rhode Island	R.I. GEN. LAWS §§ 27-41-1 to 27-41-27 (1983-1985).	<u>See also</u> REG XIX (1975).
South Carolina		S.C. CODE §§ 38-25-10 to 38-25-60 (1974); RULE 69-22 (1976).
South Dakota		S.D. CODIFIED LAWS ANN. §§ 58-41-1 to 58-41-97 (1974).
Tennessee		TENN. CODE ANN. §§ 56-32-101 to 56-32-109 (1971).
Texas	TEX. INS. COD art. 20A.01 to 20A.35 (1975) (Substantially similar to Model).	

Model Regulation Service - April 1986

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Utah		UTAH CODE ANN. §§ 31-42-1 to 31-42-32 (1973); see also INS. DEPT. REG. 74-1.
Vermont		VT. STAT. ANN. tit. 8, §§ 5101 to 5113 (1979).
Virginia	VA. CODE §§ 38.1-863 to 38.1-890 (1980).	
Virgin Islands	NO ACTION TO DATE	
Washington		WASH. REV. CODE §§ 48.46.010 to 48.46.920 (1975).
West Virginia	W.VA. CODE §§ 33-25A-1 to 33-25A-28 (1977).	
Wisconsin	NO ACTION TO DATE	Regulation pending/not model. (INS. REG. 3.50)
Wyoming	WYO. STAT. §§ 26-34-101 to 26-34-128 (1986). See also WYO. INS. REGS. ch. XIII (1986).	

CASH MANAGEMENT SYSTEM GUIDELINES

A cash collection arrangement for the collection of funds and the accounting thereon is part of today's accounting system where a very large amount of receipts or multi-company cash receipts are generated. These arrangements, which are generally performed by an organization's depository or some other outside corporation such as an affiliate or parent, enhance the timely collection and recording of cash receipts. They also increase investment return since funds are processed and banked at the earliest possible time.

The HMO shall demonstrate to its regulatory authority that the HMO will retain legal ownership of its assets and that the HMO and the regulatory authority will have access to any asset transferred to an affiliate in or out of the state within a time deemed reasonable by the regulatory authority.

The following are general guidelines indicating one way to accomplish this:

- A. Cash receipts must be under the direct control of the HMO that generated such receipts. If a system is under the control of a parent or affiliated company, receipts are to be transferred to the HMO within a reasonable period of time.
- B. Securities purchased by a parent or affiliated company must be in the name of the HMO generating the funds for such security purchases.
- C. Investments of HMOs shall not be pooled with other entities including nondomestic HMOs unless there is an agreement which vests an undivided interest to the HMO in the pooled arrangement. Such agreement shall be approved by the regulatory agency charged with the regulatory responsibility for the respective HMO.
- D. The commingling of cash or investments between HMOs is prohibited, except as provided in A.
- E. When investing in securities, HMOs must be governed by the limitations contained in the Investment Guidelines, as adopted by the state.
- F. An HMO must keep its securities within its State of domicile unless permission is granted by the appropriate regulatory authority.

Legislative History (all references are to the Proceedings of the NAIC).

1987 Proc. I (adopted).

MODEL REGULATION TO IMPLEMENT RULES REGARDING CONTRACTS AND SERVICES OF HEALTH MAINTENANCE ORGANIZATIONS

PREAMBLE

During the course of drafting this model regulation, it became apparent that the range of issues for which various states have regulations exceeds the regulatory requirements which are common to the majority of states. Further, the range of issues appears to exceed the range of topics specifically addressed in the NAIC Model Act. This is due, in part, to the rapid evolution of the HMO industry over the past several years coupled with the rapid shift to a more business-oriented environment.

Authorities created by statute vary substantially from state to state and even though it is likely that no single state currently addresses all of the topics presented in this regulation, it was the consensus of the Committee that the purview of the model regulation be broad enough to address the entire range of topics which have been identified, rather than remaining silent on certain issues on the basis of uncertainty of jurisdiction in individual states. Because of the variation of authorities which exist, it is incumbent on individual states to ascertain the limits of that authority in the application of the model regulation. Each state will thus be required to limit application of the model regulation, or seek appropriate statutory authority where such authority does not appear to presently exist.

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Section 1. Authority

This regulation is issued pursuant to the authority vested in the Commissioner (Director, Superintendent) under [cite appropriate section of law enacting the State Health Maintenance Organization Act and any other appropriate sections of law regarding the authority to issue or promulgate rules and regulations vested in the Commissioner (Director, Superintendent) and the Commissioner of Health where applicable].

Section 2. Purpose

The purpose of this regulation is to implement [cite section of law which sets forth the State Health Maintenance Organization Act] so as to assure the availability, accessibility and quality of services provided by health maintenance organizations and to provide reasonable standards for terms and provisions contained in health maintenance organization contracts and evidences of coverage.

Section 3. Applicability and Scope

This regulation shall apply on or after the effective date to all health maintenance organizations that are required to obtain a certificate of authority in this State. In the event of conflict between the provisions of this regulation and the provisions of any other regulation issued by the Commissioner (Director, Superintendent), the provisions of this regulation shall be controlling as to health maintenance organizations.

Section 4. Effective Date

- A. This regulation shall be effective on _____.
- B. No new contract or evidence of coverage shall be issued or put in force on or after [six months after date in Subsection A above] unless it complies with this regulation.
- C. No contract or evidence of coverage shall be reissued, renewed, amended or extended in this state on or after [date in Subsection B above] unless it complies with this regulation. A contract or evidence of coverage approved before [date of Subsection B] shall be deemed to be reissued, renewed, amended or extended on the date the health maintenance organization changes the terms of the contract or evidence of coverage or adjusts the premiums charged. Such contract or evidence of coverage must comply with this regulation when amended but in no event later than twelve months after the effective date of this regulation.

Section 5. Definitions

No contract or evidence of coverage delivered or issued for delivery to any person by a health maintenance organization required to obtain a certificate of authority in this State shall contain definitions respecting the matters set forth below unless such definitions comply with the requirements of this section. Definitions other than those set forth herein may be used as appropriate providing that they do not contradict these requirements. All definitions used in the contract and evidence of coverage shall be in alphabetical order. As used in this regulation and for the purpose of any terms used in the contract and evidence of coverage:

- A. "Basic health care services" means emergency care, inpatient hospital and physician care, and outpatient medical services. Mental health services or services for alcohol or drug abuse are not required to be basic health care services.

Drafting Note: State laws vary as to what services or benefits are required to be provided as basic health care services. It will probably be necessary to modify this regulation for consistency with existing state law. Federally qualified HMOs are required to provide some outpatient mental health services and some alcohol/drug abuse treatment services.

- B. "Contract holder" means a person or entity consisting of employees or eligible persons which has entered into a group contract with a health maintenance organization for the provision of specified health care services to its eligible employees or eligible persons.
- C. "Copayment" means the amount an enrollee must pay at the time of service in order to receive a specific service which is not fully prepaid.

- D. "Eligible dependent" means any member of a subscriber's family who meets the eligibility requirements set forth in Subsection D of Section 6 of this regulation.
- E. "Emergency care services" means:
- (1) Within the service area: covered health care services rendered by affiliated or non-affiliated providers under unforeseen conditions that require immediate medical attention. Emergency care services within the service area shall include covered health care services from non-affiliated providers only when delay in receiving care from the health maintenance organization could reasonably be expected to cause severe jeopardy to the enrollee's condition.
 - (2) Outside the service area: medically necessary health care services that are immediately required because of unforeseen illness or injury while the enrollee is outside the geographical limits of the health maintenance organization's service area.
- F. "Enrollee" or "member" means an individual who is enrolled in a health maintenance organization.
- G. "Evidence of coverage" means any certificate, agreement or contract issued to a subscriber setting out the coverage to which he is entitled.
- H. "Group contract" means a contract for health care services which by its terms limits eligibility to members of a specified group.
- I. "Health care services" means any services included in the furnishing to any individual of medical or dental care or hospitalization, or incident to the furnishing of such care or hospitalization; as well as the furnishing to any person of any and all other services for the purposes of preventing, alleviating, curing, or healing human illness, injury or physical disability.
- J. "Health professional" means any professional engaged in the delivery of health care services who is licensed, and practicing within the scope of such a license, where such licensing is required by state law.
- K. "Hospital" means a duly licensed institution which provides general and specialized inpatient medical care. The term "hospital" shall not include a convalescent facility, nursing home, or any institution or part thereof which is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged.
- L. "Individual contract" or "nongroup contract" means a contract for health care services issued to and covering an individual or a family.
- M. "Medical necessity" or "medically necessary" means appropriate and necessary services as determined by any provider affiliated with the health maintenance organization which are rendered to an enrollee for any condition requiring, according to generally accepted principles of good medical practice, the diagnosis or direct care and treatment of an illness or injury and are not provided only as a convenience.

Drafting Note: This definition gives the provider the authority to determine what is medically necessary. However, it does not preclude the HMO from establishing standards by which providers make their decisions as to what is medically necessary or from penalizing providers for failure to meet these standards.

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- N. "Out-of-area services" means the health care services that a health maintenance organization covers when its enrollees are outside of the service area.
- O. "Physician" means a duly licensed doctor of medicine or osteopathy practicing within the scope of such a license.
- P. "Primary care physician" means a physician who supervises, coordinates, and provides initial and basic care to members; initiates their referral for specialist care and maintains continuity of patient care.
- Q. "Provider" means any physician, hospital or other person licensed and practicing within the scope of such a license or otherwise authorized in the jurisdiction in which services are rendered to furnish health care services.

Drafting Note: The term "person" as used in this context is intended to include an association, corporation, organization, business, company or individual.

- R. "Service area" means the geographical area as approved by the Commissioner (Director, Superintendent) within which the health maintenance organization provides or arranges for health care services that are available and accessible to enrollees.

Drafting Note: The phrase "basic and supplemental" was deleted from previous drafts because some HMOs do not offer supplemental health care services.

- S. "Skilled nursing facility" means a facility that is operated pursuant to law and primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician.
- T. "Subscriber" means the individual whose employment or other status, except for family dependency, is the basis for eligibility for enrollment in the health maintenance organization.
- U. "Supplemental health care services" means any health care services other than basic health care services.

Section 6. Requirements for Contracts and Evidences of Coverage

Each subscriber shall be entitled to a contract or evidence of coverage as approved by the Commissioner (Director, Superintendent). A contract or evidence of coverage shall be delivered or issued for delivery to a subscriber within a reasonable time after enrollment, but not more than fifteen days from the later of the effective date of coverage or the date on which the health maintenance organization is notified of enrollment.

Drafting Note: The Committee suggested that the wording of this provision reflect a consumer's right to a contract or evidence of coverage within a reasonable time while also protecting an HMO from being penalized if it has not been informed of new members. Individual states may wish to add a clause as to who has the responsibility (the employer or the health maintenance organization) for delivering the evidences of coverage to group enrollees.

A. Health Maintenance Organization Information

The contract and evidence of coverage shall contain the name, address and telephone number of the health maintenance organization, and where and in what manner information is available as to how services may be obtained. A toll free phone number within the service area for calls, without charge to members, to the health maintenance organization's administrative office shall be made available and disseminated.

nated to enrollees to adequately provide telephone access for member services, problems or questions.

Drafting Note: The Committee recommended that a toll-free number needs to be made available somehow whether in a newsletter or flyer. The contract or evidence of coverage should indicate in what manner the number will be disseminated rather than list the number itself to avoid having to amend the contract or evidence of coverage in the event the number changes.

B. Entire Contract

The contract shall contain a statement that the contract, all applications and any amendments thereto shall constitute the entire agreement between the parties. No portion of the charter, bylaws or other document of the health maintenance organization shall be part of such a contract unless set forth in full in the contract or attached thereto.

Drafting Note: The application is being made part of the contract because health maintenance organizations are doing some underwriting with the inclusion of preexisting conditions. The words "or attached thereto" were added to allow for provider lists to be attached to contracts.

C. Term of Coverage

The contract and evidence of coverage shall contain the time and date or occurrence upon which coverage takes effect, including any applicable waiting periods, or describe how the time and date or occurrence upon which coverage takes effect is determined.

The contract and evidence of coverage shall contain the time and date or occurrence upon which coverage will terminate.

D. Eligibility Requirements

The contract and evidence of coverage shall contain eligibility requirements indicating the conditions that must be met to enroll as a subscriber or eligible dependent, the limiting age for subscribers and eligible dependents including the effects of Medicare eligibility, and a clear statement regarding coverage of newborn children.

[If a state has the authority to define an eligible dependent, the following provision or one that is no less favorable should be included in the regulation:]

The definition of an eligible dependent shall include:

- (1) the spouse of the subscriber;
- (2) an unmarried dependent child of the subscriber who has not reached age _____;
- (3) an unmarried dependent of the subscriber age _____ or over, who is both incapable of self support because of mental retardation, mental illness or physical incapacity which began before the child reached age _____, and chiefly dependent upon the subscriber for support and maintenance; or

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- (4) an unmarried dependent child of the subscriber age _____ through _____ who is attending a recognized college or university, trade or secondary school on a full-time basis.

[If a state has the authority to define an eligible dependent child, the following provision or one that is no less favorable should be included in the regulation:]

The definition of a dependent child shall include children who are:

- (1) related to the subscriber as either a natural child, a legally adopted child or a stepchild; or
- (2) any other child residing in the subscriber's household and who qualifies as a dependent of the subscriber or the subscriber's spouse under the United States Internal Revenue Code and the Federal Tax Regulations.

[If a state has the authority to require a health maintenance organization to cover newborn children, the following provision or one that is no less favorable should be included in the regulation:]

No contract and evidence of coverage shall contain any provision excluding or limiting coverage for a newborn child. Medically diagnosed congenital defects and birth abnormalities shall be treated the same as any other illness or injury for which coverage is provided. The contract and evidence of coverage may require that notification of birth of a newborn child and payment of any required premium must be furnished to the health maintenance organization within thirty-one days after the date of birth in order to have coverage continue beyond such thirty-one day period.

Drafting Note: Although state laws vary as to coverage for eligible dependents and newborns, many states require such coverage so provisions have been included. If a state does not have authority in these areas, only the first paragraph should be included when adopting this regulation.

The Committee decided to add language to take into account that some state laws will be different and to deal with multistate HMOs.

E. Benefits and Services within the Service Area

The contract and evidence of coverage shall contain a specific description of benefits and services available within the service area.

F. Emergency Care Services

The contract and evidence of coverage shall contain a specific description of benefits and services available for emergencies twenty-four hours a day, seven days a week, including disclosure of any restrictions on emergency care services. No contract or evidence of coverage shall limit the coverage of emergency services within the service area to affiliated providers only.

G. Out of Area Benefits and Services

The contract and evidence of coverage shall contain a specific description of benefits and services available out of the service area.

H. Copayments, Limitations and Exclusions

The contract and evidence of coverage shall contain a description of any copayments, limitations or exclusions on the services, kind of services, benefits, or kind of benefits to be provided, including any copayments, limitations or exclusions due to preexisting conditions, waiting periods or an enrollee's refusal of treatment.

I. Cancellation or Termination

The contract and evidence of coverage shall contain the conditions upon which cancellation or termination may be effected by the health maintenance organization or the subscriber.

J. Renewal

The contract and evidence of coverage shall contain the conditions for, and any restrictions upon, the subscriber's right to renewal.

K. Reinstatement

The contract and evidence of coverage shall contain the conditions for, and any restrictions upon, the subscriber's right to reinstatement.

L. Grace Period

The contract and evidence of coverage shall provide for a grace period of not less than thirty days for the payment of any premium except the first, during which coverage shall remain in effect if payment is made during the grace period. During the grace period, the health maintenance organization shall remain liable for providing the services and benefits contracted for, the contract holder shall remain liable for the payment of the premium for the time coverage was in effect during the grace period, and the subscriber shall remain liable for any copayments owed.

Drafting Note: Under this subsection the health maintenance organization would not have to notify the subscriber of default in payment, but the subscriber would be protected from obtaining services and then finding out that he had no coverage because the employer had not paid the premium.

The Committee decided that a grace period was needed so that an HMO cannot cancel for late payment as long as payment is made within the grace period.

M. Claims

The contract and evidence of coverage shall contain procedures for filing claims that include:

- (1) any required notice to the health maintenance organization;
- (2) if any claim forms are required, how, when and where to obtain and submit them;
- (3) any requirements for filing proper proofs of loss;
- (4) any time limit of payment of claims;

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- (5) notice of any requirement for resolving disputed claims including arbitration; and
- (6) a statement of restrictions, if any, on assignment of sums payable to the enrollee by the health maintenance organization.

N. Complaint System and Arbitration

In compliance with Subsection D of Section 9 of this regulation, the contract and evidence of coverage shall contain a description of the health maintenance organization's method for resolving enrollee complaints, incorporating procedures to be followed by the enrollee in the event any dispute arises under the contract, including any requirements for arbitration.

O. Continuation of Coverage

A group contract and group evidence of coverage shall contain a provision that any member who is an inpatient in a hospital or a skilled nursing facility on the date of discontinuance of the group contract shall be covered in accordance with the terms of the group contract until discharged from such hospital or skilled nursing facility. Such member may be charged the appropriate premium for coverage that was in effect prior to discontinuance of the group contract.

Drafting Note: Group contracts and evidences of coverage are required to contain a continuation of coverage provision to protect enrollees who are in the hospital or a skilled nursing home when a contract is discontinued. Requirements concerning medically necessary care and copayments would still apply.

Standards no less favorable than the applicable federal requirements may be required by each state in formulating their rules and regulations.

P. Conversion of Coverage

- (1) The contract and evidence of coverage shall contain a conversion provision which provides that each enrollee has the right to convert coverage to an individual health maintenance organization contract in the following circumstances:

- (a) upon termination of eligibility for coverage under a group or individual contract; or
- (b) upon termination of the group contract.

To obtain the conversion contract, an enrollee shall submit a written application and the applicable premium payment within thirty-one days after the date the enrollee's eligibility for coverage terminates.

Drafting Note: Since health benefits coverage is an important asset, an enrollee under a group contract should have conversion rights if the group contract is terminated or cancelled.

- (2) A conversion contract shall not be required to be made available if:
 - (a) the enrollee's termination of coverage occurred for any of the reasons listed in Subparagraphs (1)(a), (b), (c), (f) or (g) of Subsection B of Section 7 of this regulation;

- (b) the enrollee is covered by or is eligible for benefits under Title XVIII of the United States Social Security Act;
 - (c) the enrollee is covered by or is eligible for similar hospital, medical or surgical benefits under state or federal law;
 - (d) the enrollee is covered by or is eligible for similar hospital, medical or surgical benefits under any arrangement of coverage for individuals in a group;
 - (e) the enrollee is covered for similar benefits by an individual policy or contract; or
 - (f) the enrollee has not been continuously covered during the three-month period immediately preceding that person's termination of coverage.
- (3) The conversion contract shall provide as a minimum to its enrollees basic health care services.
 - (4) The conversion contract shall begin coverage of the enrollee formerly covered under the group or individual contract on the date of termination from the group or the former individual contract.
 - (5) Coverage shall be provided without requiring evidence of insurability and shall not impose any preexisting condition limitations or exclusions as described in Subsection A of Section 7 other than those remaining unexpired under the contract from which conversion is exercised. Any probationary or waiting period set forth in the conversion contract shall be deemed to commence on the effective date of the enrollee's coverage under the prior contract.

Q. Extension of Benefits for Total Disability

- (1) Each group contract issued by a health maintenance organization shall contain a reasonable extension of benefits upon discontinuance of the group contract with respect to enrollees who become totally disabled while enrolled under the contract and who continue to be totally disabled at the date of discontinuance of the contract.
- (2) Upon payment of premium at the current group rate, coverage shall remain in full force and effect for a reasonable period of time not less than 180 days, or until such time as the enrollee is no longer totally disabled, or until such time as a succeeding carrier elects to provide replacement coverage to that enrollee without limitation as to the disabling condition.
- (3) Upon termination of the extension of benefits, the enrollee shall have the right to convert coverage as provided in Subsection P of Section 6 of this regulation.

R. Coordination of Benefits

The contract and evidence of coverage may contain a provision for coordination of benefits that shall be consistent with that applicable to other carriers in the juris-

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diction. Any provisions or rules for coordination of benefits established by a health maintenance organization shall not relieve a health maintenance organization of its duty to provide or arrange for a covered health care service to any enrollee because the enrollee is entitled to coverage under any other contract, policy or plan, including coverage provided under government programs. The health maintenance organization shall be required to provide covered health care services first and then, at its option, seek coordination of benefits.

S. Right to Examine Contract

An individual contract shall contain a provision stating that a person who has entered into an individual contract with a health maintenance organization shall be permitted to return the contract within ten days of receiving it and to receive a refund of the premium paid if the person is not satisfied with the contract for any reason. If the contract is returned to the health maintenance organization or to the agent through whom it was purchased, it is considered void from the beginning. However, if services are rendered or claims are paid for such person by the health maintenance organization during the ten-day examination period, the person shall not be permitted to return the contract and receive a refund of the premium paid.

T. Subrogation/Injuries Caused by Third Parties

The contract and evidence of coverage shall not contain any provisions concerning subrogation for injuries caused by third parties unless the wording has been approved by the Commissioner (Director, Superintendent).

U. Conformity with State Law

Any contract and evidence of coverage that contains any provision not in conformity with [cite section of law which sets forth the state Health Maintenance Organization Act] shall not be rendered invalid but shall be construed and applied as if it was in full compliance with this regulation and [cite section of law which sets forth the state Health Maintenance Organization Act].

Section 7. Prohibited Practices

A. Preexisting Conditions

- (1) A health maintenance organization may include in its individual contract a provision setting forth reasonable exclusions or limitations of services for preexisting conditions at time of enrollment. However, no such exclusions or limitations shall be for a period greater than two years.
- (2) No health maintenance organization shall exclude or limit services for a preexisting condition when the enrollee transfers coverage from one individual contract to another or when the enrollee converts coverage under his conversion option, except to the extent of a preexisting condition limitation or exclusion remaining unexpired under the prior contract. Any required probationary or waiting period shall be deemed to have commenced on the effective date of coverage under the prior contract. The health maintenance organization contract shall disclose any preexisting condition limitations or exclusions that are applicable when an enrollee transfers from a prior HMO contract.

- (3) A preexisting condition shall not be defined more restrictively than the following:
 - (a) The existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a two-year period preceding the effective date of coverage under the health care plan; or
 - (b) a condition for which medical advice or treatment was recommended by a physician or received from a physician within a two-year period preceding the effective date of coverage under the health care plan.
- (4) No group contract or evidence of coverage shall exclude or limit services for a preexisting condition.

B. Termination of Coverage

- (1) No health maintenance organization shall cancel or terminate coverage of services provided an enrollee under a health maintenance organization contract except for one or more of the following reasons:
 - (a) failure to pay the amounts due under the contract;
 - (b) fraud or material misrepresentation in enrollment or in the use of services or facilities;
 - (c) material violation of the terms of the contract;
 - (d) failure to meet the eligibility requirements under a group contract, provided that a conversion option is offered;
 - (e) termination of the group contract under which the enrollee was covered;
 - (f) failure of the enrollee and the primary care physician to establish a satisfactory patient-physician relationship if:
 - (i) it is shown that the health maintenance organization has, in good faith, provided the enrollee with the opportunity to select an alternative primary care physician,
 - (ii) the enrollee has repeatedly refused to follow the plan of treatment ordered by the physician, and
 - (iii) the enrollee is notified in writing at least thirty days in advance that the health maintenance organization considers the patient-physician relationship to be unsatisfactory and specific changes are necessary in order to avoid termination; or
 - (g) such other good cause agreed upon in the contract and approved by the Commissioner (Director, Superintendent).

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However, coverage shall not be cancelled or terminated on the basis of the status of the enrollee's health nor on the fact that the enrollee has exercised his rights under the health maintenance organization's complaint system by registering a complaint against the health maintenance organization.

- (2) No health maintenance organization shall cancel or terminate an enrollee's coverage for services provided under a health maintenance organization contract without giving the enrollee written notice of termination which shall be effective at least fifteen days from the date of mailing or, if not mailed, from the date of delivery and which shall include the reason for termination. For termination due to nonpayment of premium, the grace period as required in Subsection L of Section 6 of this regulation shall apply. No written notice of termination shall be required to be given for termination due to non-payment of premium.
- (3) No health maintenance organization that provides in the contract and evidence of coverage, that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children shall terminate the coverage of such child if the child is and continues to be both:
 - (i) incapable of self support because of mental retardation, mental illness or physical incapacity, and
 - (ii) chiefly dependent upon the subscriber for support and maintenance.

Proof of such incapacity and dependency shall be furnished to the health maintenance organization by the subscriber within thirty-one days of the child's attainment of the limiting age and subsequently as reasonably required by the health maintenance organization.

C. Unfair discrimination

No health maintenance organization shall unfairly discriminate against any enrollee or applicant for enrollment on the basis of the age, sex, race, color, creed, national origin, ancestry, religion, marital status or lawful occupation of an enrollee, or because of the frequency of utilization of services by an enrollee. However, nothing shall prohibit a health maintenance organization from setting rates or establishing a schedule of charges in accordance with relevant actuarial data.

No health maintenance organization shall expel or refuse to re-enroll any enrollee nor refuse to enroll individual members of a group on the basis of the health status or health care needs of the individual enrollee or member.

Drafting Note: The prohibition against unfair discrimination based on marital status does not prevent an HMO from using material status to determine dependent eligibility.

An HMO is not precluded from refusing to enroll groups or individuals not affiliated with a group if the HMO has adequate data to support that decision.

Section 8. Services

A. Access to Care

- (1) A health maintenance organization shall establish and maintain adequate arrangements to provide the health services contracted for by its subscribers including:
 - (a) reasonable proximity to the business or personal residences of the enrollees so as not to result in unreasonable barriers to accessibility;
 - (b) reasonable hours of operation and after-hours services;
 - (c) emergency care services available and accessible within the service area twenty-four hours a day, seven days a week; and
 - (d) sufficient providers and personnel, including health professionals, administrators and support staff, to assure that all services contracted for will be accessible to enrollees on an appropriate basis without delays detrimental to the health of enrollees.
- (2) A health maintenance organization shall make available to each enrollee a primary care physician and provide accessibility to medically necessary specialists through staffing, contracting or referral. A health maintenance organization shall provide for continuity of care for enrollees referred to specialists.
- (3) A health maintenance organization shall have written procedures governing the availability of frequently utilized services contracted for by subscribers, including at least the following:
 - (a) well-patient examinations and immunizations;
 - (b) emergency telephone consultation on a twenty-four hours per day, seven days per week basis;
 - (c) treatment of emergencies;
 - (d) treatment of minor illness; and
 - (e) treatment of chronic illnesses.

B. Basic Health Care Services

A health maintenance organization shall provide, or arrange for the provision of, as a minimum, basic health care services which shall include the following:

- (1) Emergency care services, as defined in Section 5 of this regulation.
- (2) Inpatient hospital services, meaning medically necessary hospital services including, but not limited to, room and board; general nursing care; special diets when medically necessary; use of operating room and related facilities; use of intensive care units and services; x-ray, laboratory and other diagnostic

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tests; drugs, medications, biologicals, anesthesia and oxygen services; special nursing when medically necessary; physical therapy, radiation therapy and inhalation therapy; administration of whole blood and blood plasma; and short-term rehabilitation services.

- (3) Inpatient physician care services, meaning medically necessary health care services performed, prescribed, or supervised by physicians or other health professionals including diagnostic, therapeutic, medical, surgical, preventive, referral and consultative health care services.
- (4) Outpatient medical services, meaning preventive and medically necessary health care services provided in a physician's office, a non-hospital-based health care facility, or at a hospital. Outpatient medical services shall include but are not limited to diagnostic services; treatment services; laboratory services; x-ray services; referral services; and physical therapy, radiation therapy and inhalation therapy. Outpatient services shall also include preventive health services which shall include, at least a broad range of voluntary family planning services, services for infertility, well-child care from birth, periodic health evaluations for adults, screening to determine the need for vision and hearing correction, and pediatric and adult immunizations in accordance with accepted medical practice.

C. Out-of-Area Services and Benefits

- (1) Out-of-area services shall be subject to the same copayment requirements set forth in Subsection C of Section 9.
- (2) When an enrollee is traveling or temporarily residing out of a health maintenance organization's service area, a health maintenance organization shall provide benefits for reimbursement for emergency care services and transportation which is medically necessary and appropriate under the circumstances to return the enrollee to a health maintenance organization provider, subject to the following conditions:
 - (a) The condition could not reasonably have been foreseen;
 - (b) The enrollee could not reasonably arrange to return to the service area to receive treatment from the health maintenance organization's provider;
 - (c) The travel or temporary residence must be for some purpose other than the receipt of medical treatments; and
 - (d) The health maintenance organization is notified by telephone within twenty-four hours of the commencement of such care unless it is shown that it was not reasonably possible to communicate with the health maintenance organization in such time limits.
3. Services received by an enrollee outside of the health maintenance organization's service area will be covered only so long as it is unreasonable to return the enrollee to the service area.

D. Supplemental Health Care Services

In addition to the basic health care services required to be provided in Subsection B of this section, a health maintenance organization may offer to its enrollee any supplemental health care services it chooses to provide. Limitations as to time and cost may vary from those applicable to basic health care services.

Section 9. Other Requirements

A. Description of Providers

- (1) A health maintenance organization shall provide its subscribers with a list of the names and locations of all of its providers no later than the time of enrollment or the time the contract and evidence of coverage are issued and upon request thereafter. If a provider is no longer affiliated with a health maintenance organization, the health maintenance organization shall provide notice of such change to its affected subscribers in a timely manner. Subject to the approval of the Commissioner (Director, Superintendent), a health maintenance organization may provide its subscribers with a list of providers or provider groups for a segment of the service area. However, a list of all providers shall be made available to subscribers upon request.

- (2) Any list of providers shall contain a notice regarding the availability of the listed primary care physicians. Such notice shall be in not less than twelve point type and be placed in a prominent place on the list of providers. The notice shall contain the following or similar language:

Enrolling in [name of HMO] does not guarantee services by a particular provider on this list. If you wish to be sure of receiving care from specific providers listed, you should contact those providers to be sure that they are accepting additional patients for [name of HMO].

B. Description of the Services Area

A health maintenance organization shall provide its subscribers with a description of its service area no later than the time of enrollment or the time the contract and evidence of coverage is issued and upon request thereafter. If the description of the service area is changed, the health maintenance organization shall provide at such time a new description of the service area to its subscribers.

C. Copayments

A health maintenance organization may require copayments of enrollees as a condition for the receipt of specific health care services. Copayments for basic health care services shall be shown in the contract and evidence of coverage as a specified dollar amount. Copayments shall be the only allowable charge, other than premiums, assessed to subscribers for basic and supplemental health care services.

D. Complaint System

- (1) A complaint system shall be established and maintained by a health maintenance organization to provide reasonable procedures for the prompt and effective resolution of written complaints.

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- (2) A health maintenance organization shall provide complaint forms to be given to enrollees who wish to register written complaints. Such forms shall include The address and telephone number to which complaints must be directed and shall also specify any required time limits imposed by the health maintenance organization.
- (3) The complaint system shall provide for (i) written acknowledgement of complaints and (ii) complaints to be resolved or to have a final determination of the complaint by the health maintenance organization complaint system within a reasonable period of time, but not more than ninety days from the date the complaint is registered. This period may be extended (i) in the event of a delay in obtaining the documents or records necessary for the resolution of the complaint, or (ii) by the mutual written agreement of the health maintenance organization and the enrollee.
- (4) Pending the resolution of a written complaint filed by a subscriber or enrollee, coverage may not be terminated for any reason which is the subject of the written complaint, except where the health maintenance organization has, in good faith, made a reasonable effort to resolve the written complaint through its complaint system and coverage is being terminated as provided for in Subsection B of Section 7.
- (5) If enrollees complaints and grievances may be resolved through a specified arbitration agreement, the enrollee shall be advised in writing of his rights and duties under the agreement at the time the complaint is registered. Any such agreement must be accompanied by a statement setting forth in writing the terms and conditions of binding arbitration. Any health maintenance organization that makes such binding arbitration a condition of enrollment must fully disclose this requirement to its enrollees in the contract and evidence of coverage.

Section 10. Penalties

Any violation of this regulation shall be punished as provided for in [cite applicable section of law] and any other applicable law of this State.

Section 11. Severability

If any provision of this regulation or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the regulation and the application for such provision to other persons or circumstances shall not be affected thereby.

Legislative History (all references are to the Proceedings of the NAIC).

1987 Proc. I (adopted).

Model Regulation Service - January 1987

**MODEL REGULATION TO IMPLEMENT RULES
REGARDING CONTRACTS AND SERVICES
OF HEALTH MAINTENANCE ORGANIZATIONS**

The date in parentheses is the effective date of the legislation or regulation, with latest amendments.

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Alabama	NO ACTION TO DATE	
Alaska	NO ACTION TO DATE	
Arizona	NO ACTION TO DATE	
Arkansas	NO ACTION TO DATE	
California	NO ACTION TO DATE	
Colorado	NO ACTION TO DATE	
Connecticut	NO ACTION TO DATE	
Delaware	NO ACTION TO DATE	
D.C.	NO ACTION TO DATE	
Florida		FLA. ADMIN. CODE § 4-31.01 to 4-31.20 (1972).
Georgia		GA. ADMIN. COMP. ch. 120-2-33 (1980/1986).
Guam	NO ACTION TO DATE	
Hawaii	NO ACTION TO DATE	
Idaho		IDAHO INS. REGS. 26 (1974).
Illinois		ILL. ADMIN. REG. tit. 50 §§ 6101.10 to 6101.160 (1976).
Indiana	NO ACTION TO DATE	
Iowa		IOWA ADMIN. CODE § 510-40.1 to 510-40.14 (1974/1985).

Model Regulation Service - January 1987

**MODEL REGULATION TO IMPLEMENT RULES
REGARDING CONTRACTS AND SERVICES
OF HEALTH MAINTENANCE ORGANIZATIONS**

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Kansas	NO ACTION TO DATE	
Kentucky		806. KY ADMIN. REGS. 38:010 to 38:080 (1975/1985).
Louisiana	NO ACTION TO DATE	
Maine		ME. INS. REG. ch. 190 (1976).
Maryland		MD. ADMIN. CODE tit. 9 subtit. 30 ch. 55 §§ .01 to .05 (1977).
Massachusetts	NO ACTION TO DATE	
Michigan	NO ACTION TO DATE	
Minnesota	NO ACTION TO DATE	
Mississippi	NO ACTION TO DATE	
Missouri	NO ACTION TO DATE	
Montana	NO ACTION TO DATE	
Nebraska	NO ACTION TO DATE	
Nevada		NEV. ADMIN. CODE § 695C.010 to 695C.280 (1974/1986).
New Hampshire		N.H. ADMIN. CODE INS. 2201.01 to 2201.12 (1982).
New Jersey	NO ACTION TO DATE	
New Mexico	NO ACTION TO DATE	
New York	NO ACTION TO DATE	
North Carolina	NO ACTION TO DATE	

Model Regulation Service - January 1987

**MODEL REGULATION TO IMPLEMENT RULES
REGARDING CONTRACTS AND SERVICES
OF HEALTH MAINTENANCE ORGANIZATIONS**

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
North Dakota	NO ACTION TO DATE	
Ohio		OHIO INS. REGS. RULE 3901-1-30 (1976/1980).
Oklahoma	NO ACTION TO DATE	
Oregon	NO ACTION TO DATE	
Pennsylvania	NO ACTION TO DATE	
Puerto Rico	NO ACTION TO DATE	
Rhode Island	NO ACTION TO DATE	
South Carolina		S.C. INS. R. 69-22.
South Dakota	NO ACTION TO DATE	
Tennessee	NO ACTION TO DATE	
Texas	NO ACTION TO DATE	
Utah		UTAH INS. REG. 74-1 (1974).
Vermont	NO ACTION TO DATE	
Virgin Islands	NO ACTION TO DATE	
Virginia	NO ACTION TO DATE	
Washington	NO ACTION TO DATE	
West Virginia	NO ACTION TO DATE	
Wisconsin	NO ACTION TO DATE	
Wyoming		WYO. INS. REGS. ch. XIII (1986).

Mr. POMEROY. Mr. Chairman, the NAIC, I think, normally urges the regulation of insurance entities at a State level. But when the Federal Government is contracting through a local insurance mechanism, like an HMO, with Federal dollars involved, I think the Federal Government should write in whatever standards they feel are necessary to make sure that they get a good buy for their money.

Chairman STARK. But we do not have any. You all have had how many years of experience as your respective offices had regulating insurance companies? You have a tradition there. You probably all know instinctively what a right reserve ratio is, what right equity ratios are, reserve ratios for mutual companies.

I do not think, and, Bill, you can answer this—I am not asking for a pejorative answer—but I do not think that you could have witnessed much expertise in the Florida case we all are referring to out of HCFA. I do not think they have many people trained to monitor.

Did you find them there at the beginning of the problem?

Mr. GUNTER. Mr. Chairman, I think we both know that they would acknowledge a lack of expertise in that area.

Chairman STARK. And they were late. I mean the problem had grown and grown by the time we were aware of it at the Federal level. We all know that. Dr. Bowen has been as helpful as anybody who tried to correct the problem. So I am not looking to cast aspersions here.

I am just saying the realistic view is that we do not know anything about it. And basically we, being the Federal Government, have never regulated insurance. It is such a foreign field to us. And HMO's begin to take on a little of that complexion.

So, do you want us to take your standards and write them into law and you guys do the investigation? Now, that is done in some States where we have Medicaid administered by various State organizations. And I guess I am really asking the insurance commissioners to come forth and make a suggestion. It would be helpful to us in not only insuring the financial integrity of this program, but in making sure we do not end up with a lot of people without any care because of unscrupulous operators or poor management.

Mr. GUNTER. As you and the committee are well aware, the HMO industry across the country, and certainly in Florida, has shown tremendous growth in just recent years. I think primarily because of the Federal participation.

And so we have seen a bit of a lag in responsible regulation.

The NAIC now is pressing in this arena, and as has been mentioned by my colleague, we do have a model act which was amended again and strengthened as late as December of this past year in our national meeting in Orlando.

In Florida, our own regulatory mechanism relating to HMO's provides for and requires insolvency insurance. It has minimum net worth requirements. It has reserving requirements—

Chairman STARK. Insolvency insurance would be similar to a State savings and loan insurance fund, I mean where—

Mr. GUNTER. No. Actually, it provides for or calls for the HMO entity itself to purchase insurance against insolvency.

Chairman STARK. And you all estimate the adequacy of the surety bond?

Mr. GUNTER. That is correct. And in fact the entity you mention has such insurance, interestingly.

We also require frequent reporting under the Florida law now, as well as examinations on a consistent basis. So we are moving in the right direction. We still have a ways to go. But, believe you me, we are conscious of this whole area and its importance, and want to work with the Congress in discharging our part of the picture.

Chairman STARK. Are the standards, and I would ask you both just yes or no, that NAIC put forth tough enough to suit Florida?

Mr. GUNTER. They are not tough enough to suit me.

Chairman STARK. How about North Dakota?

Mr. POMEROY. We need to look at it further.

Chairman STARK. Okay. So you are saying there are some States that would like them tougher and some who might think they are restrictive.

Have you had any—

Mr. GUNTER. Some States that do not understand the problem.

Chairman STARK. Have you had any real outcries of overregulation or too much Government interference as directed at your model?

Mr. GUNTER. Yes, sir, we have heard that cry.

Chairman STARK. How about patients? Have you heard that your regulations would hold down the quality of care?

Mr. GUNTER. We do not hear that from patients. We hear that from the companies.

Mr. POMEROY. We hear some objection from the providers in terms of the quality of care monitoring of an HMO. They are not used to having their files second guessed as HMO regulation requires.

Mr. GUNTER. Interestingly, in the upcoming legislative session in Florida, we are proposing new regulations and a new statute on the quality of care delivery for HMO's.

Chairman STARK. Let me ask you this: it is up to each State to voluntarily accept your recommended guidelines, is that correct? Yours is just a model for States in your association.

Mr. GUNTER. That is correct. However—

Chairman STARK. How many States have accepted them?

Mr. GUNTER. We can get that information for you.

Chairman STARK. Any guess? Half? Not many?

Mr. POMEROY. I am sorry. I do not know.

Mr. GUNTER. I would suspect that it has been fairly widely adopted because it is the only—without that, they would have to completely invent their own regulation of HMO's. I would expect it is pretty widely adopted.

Chairman STARK. Let me then pose one more question, just your own opinions.

Let's assume that we adopted a policy which provided a payment mechanism for HMOs' Medicare beneficiaries, and required that, as a qualification, the States must have a regulatory requirement, at least as stringent as your model program.

Would we get a political objection from the insurance commissioner if we wrote that into our payment specs?

Mr. POMEROY. Mr. Chairman, I do not think so. Particularly if you reference the NAIC model.

Chairman STARK. Well, now, the next question is tougher though.

What if we decided that those specifications were not strong enough? Mr. Gunter has suggested that he would like a little tougher than the model, and you are not sure. So what if we begin to say, you want at least a minimum of certain reserve requirements as a percentage, and let's just pick an arbitrary number, 10, and we decided maybe we want to increase this number up to 12.

Would that then bring a reaction from the insurance commissioners that we are interfering in your field?

Mr. GUNTER. Once again, I think you get into the question area of what it takes from a financial standpoint to regulate these entities. And to the extent that you mandate in that arena without adequate data, that is to the extent you may run into political problems.

Chairman STARK. Final question.

Would either of you consider, or have you considered administering the regulation of HMO's, financial regulation, under a contract as we do with some States for administering Medicaid? Is there any reason we could not contract with the Florida Department of Insurance to regulate the financial aspects of HMO's in Florida?

Mr. GUNTER. I do not have any problem with that. We would have to raise the commissioners' salaries, I am sure.

Mr. POMEROY. Well, Mr. Chairman, presently we feel it is a State insurance department responsibility to regulate those matters. And we feel as State regulators we are chasing after the same concern that you have, and that is consumer protection.

We find in our organization congressional interest to be very helpful because it prods us along. But we, at the same time, like to feel we have got the expertise to be able to best address the consumer protection issues without undue disruption of the marketplace. And so we would like to think we are the experts, but we certainly are responsive to congressional interests and pressure frankly to toughen up the standards.

Chairman STARK. And I understand that. But you have got an unusual situation here.

We have got one policy and one company and one person paying all the premiums, and 33 or 34 million beneficiaries equally divided throughout all your States. So that it seems to me that we have a somewhat more unique situation than just being a lifeline insurance company of America and Pru in six different policies.

We may very much create a workload for you in terms of going out and actually doing the investigation. If an HMO is similar in some respects to an insurance company, we are certainly creating a bunch of them right in your State. And not only creating them but encouraging them.

And my question is who is going to look after them?

Mr. POMEROY. Mr. Chairman, we like to think that the State regulators will have adequate protections. But I think that when the Federal Government is paying premium to a private entity, the Federal Government has got a right to regulate and write what-

ever standards it wants to apply to that private entity which is selling the Federal Government a service.

Chairman STARK. Would you be willing to help us enforce it?

Mr. POMEROY. Surely.

Mr. GUNTER. One of the questions, Mr. Chairman, that you would have to deal with in that specific area would be the fact that obviously you have some federally-qualified HMO's and you have other HMO's that are not federally-qualified. And so the question of whether you would have different standards imposed from HMO to HMO would be something that would have to be worked out.

Chairman STARK. Mr. Chandler.

Mr. CHANDLER. I have no questions.

Chairman STARK. Mr. Daub?

Mr. DAUB. I am not sure I am hearing you correctly.

Are you saying that you think all the States would very much like to see the Federal Government preempt them by creating a set of standards and forcing you to administer them through medigap and supplemental insurance people? I mean were you dancing around that or not?

Mr. GUNTER. I think we have already crossed that particular bridge, Congressman.

Mr. DAUB. You want us to make Baucus tougher and mandate it?

Mr. GUNTER. We are not saying you need necessarily to make Baucus tougher. The standards that have been imposed are what they are, we in the National Association of Insurance Commissioners frankly intend to build on those standards as already set. And as chair, and my colleague here is a member of the task force that is charged with the responsibility of doing just that.

We have made progress beyond Baucus already as to our own position in the NAIC, and in many of the States.

Mr. DAUB. Well, when you testify that you are interested in the regulation, and then you indicate that you do not want it to be so onerous as to disrupt the markets, what do you mean by that? Is that your throwaway to the private sector? We still want you to offer medigap, but are we going to do all we can to be sure that it is uniform?

Mr. POMEROY. Congressman, if I might.

Basically what I am referring to there when I talk about undue disruption at the marketplace, I am talking about mandating loss ratios in a vacuum, setting loss ratios at a number which may seem to be attractive from a consumer standpoint, say 80 percent.

But I think that doing that in a vacuum may raise real havoc with the willingness of companies to make a product available in a given area. And so that is what I mean when I talk about marketplace disruption.

Mr. DAUB. Let us get an estimate here. Are medigap insurance companies, on a more or less basis, doing a better job today or a worse job than they did before Baucus in your States? If you do not want to testify generally, in the State of Florida and the State of North Dakota, better or worse?

Mr. POMEROY. In the State of North Dakota, better.

Mr. GUNTER. That is hard to say in Florida. We feel like because frankly of the percentage of retired people that live in our State, that is an issue that we were somewhat out in front of, even in

comparison with many of our sister States, as to the regulation of medigap insurance.

So I think——

Mr. DAUB. Better or worse? How long have you been commissioner?

Mr. GUNTER. Ten years.

Mr. DAUB. Ten years. Well, in your experience, better or worse?

Mr. GUNTER. I would give it the benefit of the doubt and say we are better as a result of it.

Mr. DAUB. Well, I guess not the State, but are insurance companies in your States doing better now as a result of Baucus and the oversight that allows you to give to what their interests are in the State on behalf of those insurers that are in your State? I mean are they cheating, are they not following the rules? In other words, if regulation works, we ought to know if it is working. If it is not working, it is getting worse, we ought to know that.

Mr. GUNTER. We had standards, we had laws, we had regs in Florida prior to Baucus. We think that the overall national thrust obviously increased consciousness across the country, and that benefitted us in tightening up and increasing the oversight on the part of the Florida Insurance Department with regard to this whole area.

We have now in our own statute requirements beyond Baucus. For example, the free look provision in Baucus is 10 days; ours is 30 days. So we have built upon Baucus. We were already in the business before Baucus appeared on the national scene.

Mr. DAUB. Well, let us talk about HMO's for just a minute.

Now, the Florida HMO that has got a lot of attention, of course, was the demonstration project. It also had a waiver from the fundamental requirement, if I recall correctly, that no more than 50 percent of its enrollees be eligible for the Federal reimbursement under Medicare. Is that not correct?

Mr. GUNTER. I believe that is correct.

Mr. DAUB. Because that 50 percent rule otherwise does involve the States and private sector in making sure that HMO, at least to start with, has a pretty good balance and some financial solvency. And then other provisions of TEFRA lay on a whole bunch of fiscal and financial requirements for those.

So I think that, Mr. Chairman, from your questions with respect to HMO's that we do have some pretty good rules in place.

Mr. GUNTER. Congressman, I know you are aware that was perhaps the first or certainly one of the first HMO's to have the type relationship with the Federal Government that you have described. And certainly as a result of that experience, and the unbelievable growth of that individual HMO entity, we have learned a great deal as a result of some of those experiences. We significantly tightened our regulatory mechanism in the State of Florida, and I think, have given a good bit of our experience to the National Association of Insurance Commissioners and, as a result, amendments have and will be adopted in the NAIC model in this area.

Mr. DAUB. So you do still feel, aside from the HMO experience in that one case in Florida, that there ought to be more national regulatory standards on HMO's?

Mr. GUNTER. Well, I am suggesting that this is an area where Federal money is involved, and really that is a policy judgment that Congress is going to have to come to.

Mr. DAUB. Is one of your committees looking at this now? Do I get that impression?

Mr. GUNTER. As far as Federal involvement, no, sir. But as far as the States' responsibility, absolutely.

Mr. DAUB. I guess I would be curious about it if your group would look at this issue and give us the benefit of your thinking about, and from the expertise you have, taking a look at TEFRA and the other rules that are in place. I mean Florida did have one bad experience. We as a government may have contributed to it by waiving the rule on 50-50 over 65, under 65, and the blend. It was a very important rule. We think it has added to the soundness of other HMO's, and you are right, that was the first one, and it just grew. I mean it was an amazing story, as a matter of fact. And I think we learned from it too.

But I would not ask the question, but offer the warning, that there are lots of rules in place now, and your committees may not have studied them particularly. And I would worry that if you had studied them, and then you were going to testify here that we should regulate more, that we would really be invading the States' prerogatives. That would bother me a great deal if that were your group's position.

Mr. POMEROY. Well, I would just like to be eager too, so unless I have conveyed something inadvertently, we are not here asking for Federal regulation of HMO's. We came to talk about how the NAIC and State insurance departments will respond to the regulation of Medicare supplement products after the catastrophic health care is passed.

On the issue of HMO's, it is my view that we have the State regulation presently. I am aware of Federal requirements, particularly where there is Federal money is involved presently, and it is my position that if there is Federal money involved in the participation project, the Federal Government can look at what standards it wants to see in an HMO. But I am quick to say that neither Commissioner Gunter nor myself is authorized by the NAIC to come here and ask for more Federal regulation. That is not what I meant to convey.

Mr. GUNTER. That is correct, Congressman.

Chairman STARK. I want to thank you both very much. You have been very informative and very helpful.

The Chair would like to announce that it is our intention, with the concurrence of the members, to continue right on through lunch. I would expect some of the members may have to absent themselves from time to time. But, for the benefit of the audience and the other panels, we will continue right on through.

Our next panel deals with outpatient prescription drugs and the elderly: Milton Silverman, Ph.D., research pharmacologist, Institute of Health Policy Studies from the University of California School of Medicine; Barbara Sabol, who is the executive deputy commissioner of the New York State Department of Social Services, accompanied by Mildred Schapiro, the associate commissioner for medical assistance from the New York State Department of

Social Services; Gordon Trapnell, president of the Actuarial Research Corp. of Annandale, VA.

I would like to welcome the panel to the committee. We have your prepared testimony, and without objection it will be put in the record in its entirety. It will be the Chair's intention to run the timing clock as a guide to you. We will ask each of you to summarize or expand on your written testimony and ask you to proceed in the order which you appear on the witness list.

Dr. Silverman, you will lead off.

STATEMENT OF MILTON SILVERMAN, PH.D., RESEARCH PHARMACOLOGIST, INSTITUTE FOR HEALTH POLICY STUDIES, SCHOOL OF MEDICINE, UNIVERSITY OF CALIFORNIA AT SAN FRANCISCO

Mr. SILVERMAN. Mr. Chairman, I think I can summarize my statement very briefly. We have over 20 years accumulated a wealth of information to prove that the appropriate use—the appropriate use—of out-of-hospital prescription drugs can improve the quality of health care, speed recovery, limit disability, decrease the need for hospitalization and surgery.

We are prepared to answer any questions that you would like to offer, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF MILTON SILVERMAN, PH.D., INSTITUTE FOR HEALTH POLICY STUDIES, SCHOOL OF MEDICINE, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

Just 20 years ago, in 1967, John Gardner—Secretary of what was then called HEW—set up the HEW Task Force on Prescription Drugs. Its assignment looked simple: Study the drug needs of the elderly—those aged 65 or more—and examine the possibilities of covering the costs of out-of-hospital drugs under the Medicare program. (In-hospital drugs were already covered.)

Dr. Philip Lee, then Assistant Secretary for Health, was named task force chairman. I was asked to serve as executive secretary and staff director. At first, we felt we might complete our job over a long weekend. It took a little longer.

It quickly became apparent that nobody knew what drugs the elderly in this country were taking—or should be taking. Nobody knew how much the elderly were paying—or how much they could afford to pay. Of particular significance, nobody seemed to know whether these prescriptions were rational—the right drug for the right patient, in the right amount at the right time, with due consideration of cost.

Getting the answers took more than a weekend. We mounted a massive nationwide survey—in fact, an international study—which took us 20 months. When we published our background papers and final report in 1968 and 1969, we presented two major conclusions:

First, we found and documented the fact that a drug insurance program is needed by the elderly in the United States.

Second, we found that such a program would be feasible both medically and economically.

We also observed that this kind of program, with one combination or another of economic and medical safeguards, had long since been put in operation in virtually every other industrialized nation in the world.

Since then, my colleagues—Dr. Lee and Mia Lydecker—and I have examined out-of-hospital drug programs in Canada, Australia, New Zealand, Japan, and a dozen countries in Western Europe. We've looked at a number of programs in the United States—the VA, CHAMPUS, Medicaid, Blue Cross/Blue Shield, and several HMOs and union programs; many of these include the elderly among their beneficiaries.

During the past few weeks, I have been reviewing the reports we made two decades ago. The numbers have all changed—in some instances to an embarrassing degree—but our conclusions today would be essentially the same. The problem has not gone away. If anything, it has become more severe.

Allow me to cite some fascinating figures. The CPI for prescription drugs rose from 100 in 1967 to 288 by last December. In that same period, the CPI for physi-

cian services rose from 100 to 442. The CPI for a hospital room soared from 100 to 780.

Twenty years ago, the average cost of an out-of-hospital prescription was \$3.48 (although about \$4.00 for the elderly). In 1985 it was close to \$13.60.

In 1967, the annual per capita cost for drugs in the general population was about \$16, but it was \$54 for the elderly. Now it's roughly \$90 for the general population but about \$230 for the elderly.

Those aged 65 or more now comprise only 12% of the total population, but they pay 30% of the total outpatient drug bill. That bill for the elderly was \$5.6 billion in 1984 and probably about \$6.0 billion in 1985.

The fact is today—as it was two decades ago—that the nature of illness and governmental policies have combined to give the elderly a bad deal. Men and women over 65 have more than their fair share of chronic illness, pain, crippling, and disability. At the same time, they have relatively fewer assets, less income, less savings, and less adequate drug insurance. And, according to a recent AARP report, of those who do not have drug insurance, 34% must pay out-of-pocket more than \$480 a year.

Within the elderly group, of course, the burdens fall unevenly. Some fortunate men and women have relatively little illness and have minimal need for drugs. Some are well able to pay for whatever drugs they do need. But others face difficulties.

Some of these less fortunate people may buy their drugs only by cutting down on needed food. Some may elect to leave their prescriptions unfilled and end up by needing costly hospitalization, expensive surgery, or other special care. Some may use up their assets until they qualify for welfare under Medicaid. But in some states, the Medicaid drug program is endangered or has already been slashed.

To me, it is difficult to understand how Medicare will pay for the visit to the physician who prescribes an outpatient drug but then declines to pay for the prescription.

Let me offer one illustration. We know today that some so-called beta-blockers can relieve the dreadful incapacitating pain in many heart disease patients with angina. The only current alternative to drug therapy is a coronary by-pass operation. Last week, I was able to get a rough approximation of what such surgery would cost at my neighborhood hospital. The price for a triple by-pass: 7 to 10 days hospitalization at \$3,000 a day, or about \$25,000; the surgeon's bill of \$5,500 for a Medicare beneficiary, \$2,200 for two assistants at \$1,100 each, and \$2,000 for the anesthetist. That totals \$34,700, and I don't think I included bills for x-rays, laboratory tests, and in-hospital drugs. It is difficult, as I noted, to understand how Medicare will pay that kind of a bill yet not pay for the out-of-hospital drugs that could make surgery unnecessary. The drugs have a price of about \$0.50 or \$1.00 a day.

Other curious examples could be cited.

The use of beta-blockers out of hospital has also paid dividends in protecting patients who have survived one myocardial infarction—that is, a coronary heart attack—from suffering a second attack.

The savings, assuming reasonably widespread use, would be between \$1.6 and \$3.0 a year. Medicare, however, doesn't pay for outpatient treatment—about \$1.00 a day.

Applied in the form of eyedrops, some of the new beta-blockers can help control the dangerous pressure that builds up inside the eye in glaucoma. This disease strikes about 2% of those over the age of 45. It ranks second only to diabetes as a cause of blindness.

It can be controlled either by surgery or by a beta-blocker such as Merck's timolol. The surgical procedure may cost as much as \$4,000 each time it is performed. The cost of drug therapy—again, about \$100 a day.

A special Arthur D. Little survey in 1984 estimated that the beta-blocker treatment could save from \$746 million to \$1.1 billion a year.

Some of the most impressive research in this field has focussed on duodenal ulcer and its control, first with SmithKline's cimetidine and later with somewhat similar products.

In 1981, we described preliminary studies suggesting that cimetidine might cut the costs for duodenal ulcer by perhaps \$300 million a year. Now we have the figures for the first 10 years of cimetidine use. In the U.S. alone, it has saved some \$2.8 billion, or \$280 million a year. Worldwide, it has saved \$5.8 billion. The cost per day—about \$2.00.

Another situation involves Roche's new antibiotic, ceftriaxone, and its application in the treatment of bone infections like osteomyelitis. In the standard method, the typical patient is put in the hospital for about a month and given the drug by intravenous injection once a day. Two recent studies, however, one at Falls Church, Vir-

ginia, the other at the University of Pennsylvania, have shown that carefully-selected, carefully-trained, and carefully-monitored patients can be sent home early and perform the injections themselves or have a relative or friend do the job. The savings in hospital room-and-board charges alone were an average of about \$4,400 per patient.

In most major states, the State Medicaid program will cover the cost of this home treatment. So will most Blue Cross and Blue Shield programs in those states. But not Medicare.

By no means do these few examples exhaust the list. We've not mentioned the classical examples of drug use to cut health care costs—as in schizophrenia, high blood pressure, and pneumococcal pneumonia.

OBJECTIVES

Once again, it seems, we are coming to grips with this challenging problem of drugs for the elderly. Every effort must be made to achieve these objectives:

- The primary goal must be improved health. The quality or health care must not be needlessly sacrificed merely to save money.

- Costs of any national drug program must nevertheless be kept at reasonable levels.

- Patients must be given protection against the catastrophic costs of illness.

- The program must aim for simplicity, with a minimum of rules, regulations, and paperwork.

- Pharmacists must receive reimbursement for not only their goods but also their services.

- The drug industry must not be deprived if incentives to support productive and innovative research.

- Wherever possible, patients must take part in the decision-making process which concerns which drug they will take (or will not take) and how they will use those drugs.

OPTIONS

In designing any program for covering out-of-hospital prescription drugs, a number of decisions must be made. Some of these will be painful.

If coverage is to be provided, it could be furnished under part A or part B of Medicare.

Not all Medicare beneficiaries should be covered. For economic or medical reasons, some don't need protection. Coverage might be limited at least at the start to those with a serious, chronic, disabling disease—or to those with specific diseases such as cancer or heart disease—or to those with exceedingly high drug expenses.

There must likewise be a limit on the eligible drug products. Certainly at the outset, any attempt to cover all drugs would be disastrous. At first, only products essential for serious chronic illness might be included. Use of a formulary must be considered. It should be a national but voluntary formulary, serving mainly as a national guideline. Any effort to force a national compulsory formulary would be strenuously resisted by most of the drug industry, and, I suspect, by most doctors.

Drug prices must be controlled. For multiple-source products, with one or more generic versions available, normal competition in the marketplace would probably keep prices low. Nevertheless, the use of high-quality, low-cost generics should be encouraged and possibly required. In the case of a single-source drug, still under patent, the manufacturer—at least in theory—could blackmail the program and charge any price it desired. In such a case, consideration might be given to purchase by the government itself, at a fair price set by the government—and, if necessary, settled in the courts—and then having the product distributed through the normal retail outlets. Authority for such step, I believe, already exists, although it might need some modification. It is known as 28 U.S. Code 1498. Or this country might consider compulsory licensing, which has been applied effectively in Canada.

There must be limitations on program expenditures. Such approaches as co-insurance, co-payment, an annual deductible, and capitation all deserve study.

Regulations and paperwork must be kept to a minimum. The vendor—that is, the pharmacist—and not the patient should do the bookkeeping, keep the records, and file the claims. Such chores are especially arduous for those of us over 65. It would be essential, of course, to have a suitable data processing system so the pharmacists can be paid promptly—and to make possible effective utilization review.

There must be constant utilization review—not to punish physicians or pharmacists or patients, but to educate them. Irrational prescribing and faulty drug use are luxuries too expensive for any program to afford.

Finally, in providing the highest possible quality of drug therapy, it must be constantly kept in mind that the objective is not simply to hold down the costs of Medicare or any other individual program. It is to hold down the costs of all health programs.

Chairman STARK. We are going to ask the other panelists to proceed. Ms. Sabol.

STATEMENT OF BARBARA J. SABOL, EXECUTIVE DEPUTY COMMISSIONER, NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES, ACCOMPANIED BY MILDRED SCHAPIRO, ASSOCIATE COMMISSIONER FOR MEDICAL ASSISTANCE, NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES

Ms. SABOL. Thank you, Congressman Stark. I am not sure I can be as brief as my colleague, so let me proceed.

I do appreciate the opportunity to appear before you to address the issues related to covering the costs of out-of-hospital prescription drugs under the Medicare program. I wish to share with you what I believe to be important and fundamental principles for considering such a proposal:

First of all, minimizing the barriers to prescription drugs for those unable to afford them; maintaining the integrity of the program; and, finally, assuring an equitable system of health care for our elderly population.

For most elderly citizens, living longer in today's society is accompanied by the development of chronic health conditions, and I thought it might be helpful to give you a profile of New York's elderly population which shows arthritis, heart disease, hypertension and diabetes as the top four chronic conditions afflicting New York elders. The high incidence of these diseases among older people means that these aged Americans frequently require prescription drugs for long-term health management, the bright side of that coin being that these conditions can be stabilized with drug therapy.

As has been pointed out earlier in today's proceedings, we have seen a sharp increase in the costs of prescription drugs in recent years. These higher prices place a heavy burden on those with moderate fixed incomes and who are dependent on drug maintenance therapy.

Some elderly persons are able to obtain prescription drugs because of their eligibility for Medicaid. The New York State's Medicaid program, the largest in the nation, has included prescription drug coverage since inception of the program in 1966. Many of our elderly poor do take advantage of these services. In fact, one-quarter of our Medicaid prescribed drug costs in Federal fiscal year 1985, over \$67 million, was encumbered by persons 65 years and older. Other individuals have sufficient personal financial resources to meet these out-of-pocket expenses. However, there remains a large number of elderly who are not eligible for Medicaid and who cannot afford to purchase necessary prescription drugs.

Recognizing that gap in services to needy elderly people, New York State this year enacted the elderly prescription insurance coverage program, called the EPIC program, to assist low- and moderate-income senior citizens with their prescription drug needs.

I have described in the written testimony what that coverage is and what the income levels are.

This program does incorporate registration fees and copayments, and your committee may want to consider similar cost-sharing strategies as a means for controlling expenditures.

In addition, let me move to another point which is maintaining the integrity of any program that would be developed. The standard and customary audit and quality control efforts, of course, must continue, but we believe closer attention must be paid to the quality of care issues related to drug programs. Our department is planning to initiate a pilot drug utilization review program as a quality assurance strategy in three counties. We recommend that serious consideration be given to including such a program should out-of-hospital prescription drugs become a covered benefit under Medicare.

In addition, to programmatic concerns, there are several management and operational issues that need to be taken into consideration; recognizing that cost containment is a major issue. The New York's Medicaid prescribed drug cost for those age 65 and older have increased an average of 18 percent over the last 3 Federal fiscal years. Part of this increase is due to higher prescription drug costs, a combination of dispensing fees and acquisition costs. Only 1 percent of the higher Medicaid drug costs for the elderly is accounted for by additional recipients. The remaining growth, 5 to 9 percent annually, results from an increase in the volume of prescriptions.

It is important to note that, unlike other programs, we do not include cost-sharing in Medicaid. Cost-sharing for persons with such little income—at or below the Federal poverty level—could, we believe, create egregious barriers to health care.

I have described very briefly the Federal maximum allowable cost program for prescription drugs and would like to point out that in New York we are taking the initiative to develop a State MAC list, or a mini-MAC, and such a proposal has been submitted to the legislature.

In addition, our legislature has passed legislation intended to extend the use of generic drugs, the DAW proposal, in which a physician's signature designates approval of generic substitutions by the pharmacist. It is estimated that this change in the prescription form will save the State's Medicaid program approximately \$8 million.

There are other cost containment proposals that are set out in the written testimony. But, in conclusion, I would like to say that an equitable program attentive to diminishing the barriers to needed prescription drugs and to enhancing the quality of life for an aged population dependent heavily on drug maintenance therapy would be an important one. Moreover, I suggest that the administrative and financial issues arising from extending Medicare coverage of prescription drugs can be resolved.

Thank you, and I would be happy to answer any questions.
[The prepared statement follows:]

Testimony by

Barbara Sabol
Executive Deputy Commissioner
New York State Department of Social Services

Congressman Stark and honorable members of the Subcommittee on Health, I am Barbara Sabol, Executive Deputy Commissioner of the New York State Department of Social Services. I appreciate the opportunity to appear before you today to address issues related to the proposal to cover the costs of out-of-hospital prescription drugs under the Medicare program. I wish to share with you what I believe are important and fundamental principles for considering this Medicare proposal: (1) minimizing the barriers to prescription drugs for those unable to afford them; (2) maintaining the integrity of the program; and (3) assuring an equitable system of health care for our elderly population.

Since the Medicare program was enacted in 1965, we have seen sharp declines in the nation's mortality rates and consequent increases in longevity. We applaud the progress of our health policies, but recognize that advancements in some areas bring about other issues that we can and must address.

For most elderly citizens, living longer in today's society is accompanied by the development of chronic health conditions. A profile of New York's elderly population, for example, shows arthritis, heart disease, hypertension, and diabetes as the top four chronic conditions afflicting older persons. The high incidence of these diseases among older people means that these aged Americans frequently require prescription drugs for long-term health management.

The brighter side is that most of these conditions can be stabilized with drug therapy. We improve the quality of life of the aging population, often as important as longevity, when we provide the elderly with greater control over their health problems. Access to affordable and appropriate drugs is an important element of quality-of-life discussions of the elderly. Further, appropriate drug treatment is a significant preventive measure to the human and financial costs associated with conditions such as strokes and the resulting hospitalization, nursing-home care, and extensive rehabilitation services.

We have seen sharp increases in the costs of prescription drugs in recent years. While prescription drug prices rose just 1.6 percent a year only a decade ago, in recent years the consumer price index for prescription drugs has been rising about 11 percent a year. These higher prices place a heavy burden on those with moderate, fixed incomes and dependent on drug-maintenance therapy.

Some elderly persons are able to obtain prescription drugs because of their eligibility for Medicaid. New York State's Medicaid program, the largest in the nation, has included prescription drug coverage since inception of the program in 1966. Many of our elderly poor take advantage of these services. In fact, one quarter of our Medicaid prescribed-drug costs in federal fiscal year 1985, about 67,700,000 dollars, were encumbered by persons 65 years and older. Other individuals have sufficient personal financial resources to meet these out-of-pocket expenses. There remains, however, a large number of elderly individuals who are not eligible for Medicaid and who cannot afford to purchase necessary prescription drugs.

We presently have a national system of health care where those with modest incomes but not eligible for Medicaid are unable to obtain needed prescription drugs. Are we in fact promoting a dual and inequitable policy and system for attending to the health care needs of our elderly population?

Recognizing the gap in services to needy elderly persons, New York State this year enacted the Elderly Prescription Insurance Coverage (EPIC) program to assist low- and moderate-income senior citizens with their prescription-drug needs. Comprehensive coverage will be available to individuals with incomes of up to \$9,000 and to married individuals with joint incomes up to \$12,000. We estimate that 500,000 of the 1.2 million elderly eligible for the EPIC program will elect to participate.

EPIC incorporates registration fees and co-payments, both of which are related to one's ability to pay. Your committee may want to consider similar cost-sharing strategies as a means for controlling expenditures. To receive comprehensive coverage under EPIC, for example, eligible individuals will be required to pay a quarterly registration fee, dependent on income, and a point-of-sale co-payment of \$3.00 to \$15.00 for each prescription, dependent on the cost of the drug. On the average, we expect that co-payments will amount to about 40 percent of the cost of the covered drugs. Participants in the program would be relieved of their obligation for co-payment when their co-payment totals reach 8 percent of income for single individuals and 6 percent of joint income for married participants. We believe that the EPIC program will go a long way in helping low- and moderate-income New Yorkers overcome barriers to needed prescription drugs.

Maintaining the integrity of the program is another important principle to bear in mind. The state of New York has expanded its audit and quality-control efforts to deter abuse in the system. Periodic spot audits of claims, evaluation of large

numbers of claims by certain types of pharmacies, and undercover operations are helping us to crack down harder on those few physicians and pharmacies that would abuse the system.

We also have begun to pay closer attention to quality-of-care issues in our Medicaid prescription-drug program. My department is planning to initiate a pilot Drug Utilization Review program as a quality-assurance strategy in a three-county area. We recommend that serious consideration be given to including such a program should out-of-hospital prescription drugs become a covered benefit under Medicare.

In addition to programmatic concerns, there are several management and operations issues to take into consideration. Cost containment is an important goal in New York State, as it is in the federal government. New York's Medicaid prescribed-drug costs for those age 65 and older have increased an average of 18 percent over the last three federal fiscal years. Part of this increase is due to higher prescription drug costs, a combination of dispensing fees and acquisition costs. New York's dispensing fee is set at \$2.60, and we utilize the published average wholesale price as the basis for estimating acquisition costs. Only 1 percent of higher Medicaid drug costs for the elderly is accounted for by additional recipients. The remaining growth, 5 to 9 percent annually, results from an increase in the volume of prescriptions.

To provide a sense of what these percentages mean, about 6.5 million claims for prescription drugs, sickroom supplies, and over-the-counter drugs were made by just over 200,000 elderly Medicaid clients in the last federal fiscal year. That comes to an average of 32 claims per elderly client; the number of claims for prescription-drugs alone would be lower. Unlike in other programs, we do not include cost-sharing in Medicaid. Cost-sharing for persons with such little income -- at or below the federal poverty level -- could create egregious barriers to health care.

One avenue New York has pursued for containing costs is promoting generic substitutions. The federal Maximum Allowable Cost (MAC) program for prescription drugs, for example, limits reimbursements for select multi-source or generic drugs. Despite criticism of the program, published studies have shown the program to be cost-effective. We feel that these savings can be even greater. Because there have been no additions to the federal MAC list in about five years, New York is taking the initiative to establish a state MAC list, or "Mini-Mac." Such a proposal has been submitted to our state Legislature.

New York recently has passed legislation intended to extend the use of generic drugs by amending the prescriber's prescription form. Effective July 1, 1987, the prescriber must expressly state whether generic substitution is to be permitted or prohibited by writing "DAW" (Dispense As Written) in a box contained on the new prescription blank. Unless "DAW" appears in such box, the physician's signature designates approval of generic substitution by the pharmacist. It is estimated that this change in the prescription form will save the state's Medicaid program approximately 8 million dollars annually.

Medicaid claims for prescription drugs are processed in the following manner. The pharmacist provides the recipient and provider identification numbers, national drug code, quantity dispensed, and payment amount on a pre-printed claim form submitted to the fiscal agent in Albany, New York. Verification of recipient Medicaid eligibility, the enrolled pharmacy, and the formulary file is made prior to paying a claim.

Pharmacies may submit claims as frequently as they wish; they are typically submitted weekly. Currently, three-quarters of all pharmacy claims are submitted on diskettes; the remainder are submitted on paper claim forms. Claims without errors are processed within ten working days from date of receipt of the claims.

About 737,000 pharmacy claims are processed each week. Annually, 154 million claims for all institutional and noninstitutional providers are processed. The cost of processing these claims is a modest \$0.20 per drug dispensed.

Control of the formulary -- an approved drug list -- is important in ensuring the quality of the program and containing costs. New York's approved legend drug list is developed by the state Commissioner of Health, with the advice and recommendations of a Technical Pharmacy Advisory Committee. This Committee represents the interests of organized professional pharmacies, independent retail pharmacies, and professional pharmacists employed with the state Departments of Health and Social Services.

A process has been established for reviewing proposals to add and delete drugs from the list. About 32 drug petitions, primarily from pharmaceutical companies, are received for consideration at each quarterly meeting of the Advisory Committee. In considering petitions that could involve a new chemical entity, a new strength, a new drug delivery system, or reformulation of an existing drug, the Committee reviews several criteria, such as whether comparably less expensive

drugs are already on the list and whether proposed drugs offer significantly greater therapeutic benefits than ones already listed. At the two most recent meetings of the Committee, more than 80 percent of the petitions were rejected.

In summary, an equitable program attentive to diminishing the barriers to needed prescription drugs and to enhancing the quality of life for an aged population dependent heavily on drug-maintenance therapy would be an important one. Moreover, I suggest that the administrative and financial issues arising from extending Medicare coverage of prescription drugs can be resolved. Thank you.

I would be pleased to answer any of your questions.

Chairman STARK. Thank you very much.
Mr. Trapnell.

**STATEMENT OF GORDON R. TRAPNELL, PRESIDENT, ACTUARIAL
RESEARCH CORP., ANNANDALE, VA**

Mr. TRAPNELL. Thank you, Mr. Chairman.

I would like to comment on some of the technical problems involved in designing a catastrophic insurance program that includes prescription drugs. The basic purpose of a catastrophic insurance program is to protect Medicare beneficiaries against the financial consequences of high out-of-pocket expenditures for medical care. Hence, the proper focus is on the total bills that an elderly individual or couple must pay for needed care.

To serve this function well, a catastrophic insurance program should consider all of the expenditures an elderly beneficiary or couple must make for their health care in relation to the income and resources available to them.

An effective program would limit any individual's or couple's total out-of-pocket liability to an amount they can afford, given whatever income or liquid savings they have.

There are many different approaches that could be followed to include prescriptions in a Medicare catastrophic program. Three of these include:

A separate program could cover prescriptions with an annual catastrophic threshold or deductible, such as \$200 or \$500. Similarly there could be a smaller deductible every quarter or every 6 months.

A second approach would be to have a combined deductible that covers the part A cost-sharing, part B cost-sharing and prescription drugs, rather than having separate deductibles for each. The deductible could then be set at a somewhat lower level than the combination of the other three deductibles without costing more.

A third general approach would be to cover only those drugs that are normally used by persons who routinely incur very high out-of-pocket expenses, the so-called chronic or maintenance drug approach. This could be tightened up further by actually requiring that the person have had a hospital stay with an appropriate DRG for the condition for which the drug is prescribed.

But for any given level of Federal expenditures, covering prescriptions subject to a common catastrophic deductible would provide the greatest protection against the financial consequences of a catastrophic illness. On any of these options, the Congress will be faced with very tough choices requiring compromises between: providing adequate protection of the elderly against the financial consequences of catastrophic illness; making sure that the elderly get all of the benefits they should from a program and that they are fully reimbursed for what they paid; minimizing the paperwork burden on patients, pharmacists and the Federal Government; and, of course, the proportion of program costs that are absorbed by administrative expenses; and the overall cost of the program.

In making these choices, it is important to concentrate on obtaining the most protection for the expenditure made. But to do this, you will have to live with aspects of the program that are not ideal

and do not guarantee absolute fairness to each covered individual or each pharmacy.

The last point I would like to make is that the cost of catastrophic programs tend to increase much more rapidly than other expenditures in the Federal budget. In particular, the first year outlay is not a good index of the ongoing cost of a program.

Consequently, it is most important with a catastrophic program that the Congress look at the long-range costs of the program as well as the costs in the first few years.

My written comments go into much more detail about the options available and the dilemmas that the Congress faces in designing a program that best meets the needs of the beneficiaries. I am sure you will be hearing more about these tough choices from your staff.

I thank you for this opportunity to appear here today.

[The prepared statement follows:]

OPTIONS FOR COVERAGE OF PRESCRIPTION DRUGS IN A MEDICARE CATASTROPHIC PROGRAM

Gordon R. Trapnell, F.S.A.

Testimony before the Ways and Means Committee: March 30, 1987

1. Introduction

I am Gordon R. Trapnell, a Fellow of the Society of Actuaries, and President of the Actuarial Research Corporation. I have been advising the staff of this committee from time to time over many years, beginning in 1965 when, as a member of the Office of the Actuary staff, I helped draft Part B of Medicare. For example, I am responsible for the phrase "Customary and prevailing fees" - and all the trouble that idea has caused. But I can also point out that the \$3 initial premium rate I recommended for Part B did prove to be self supporting for the period projected, something that doesn't happen often with new social insurance programs.

I am here today to provide technical assistance in describing the ways in which prescription drugs can be included in a Medicare catastrophic program. I will also describe some of the difficult choices that must be made in designing a program that best meets the needs of beneficiaries within the funding available.

2. General considerations

The basic purpose of a catastrophic insurance program is to protect Medicare beneficiaries against the financial consequences of high out of pocket expenditures for medical care. Hence the proper focus is on the total bills that an elderly individual or couple must pay for needed care.

An important perspective is that the Administration proposal is essentially a financial catastrophic insurance program. The catastrophe insured against is not having enough money. For those with assets, it is protection against the loss of savings, home, automobile, or other treasured assets. For those less fortunate, it may provide the means to buy prescription drugs when large medical bills have exhausted available income and savings.

To serve this function well, a catastrophic insurance program should consider as many as practical of the expenditures an elderly beneficiary or couple must make for their health care in relation to the income and resources available to them.

An effective catastrophic program would limit any individual's or couple's out of pocket liability to an amount they could afford, given whatever income or liquid savings they have. This amount that can be afforded is the appropriate deductible. Since some reliance may be placed on liquid savings and since most medical bills can be paid over several months, the deductible may relate to a multiple month period. Most actual proposals, like the Administration's proposal, would limit total out of pocket payments within a calendar year period. With this long a period, however, persons satisfying the deductible in one year should not face the same amount again the following year.

3. Trade offs

In shaping a catastrophic insurance program for Medicare beneficiaries, the Congress will be faced with very tough choices, requiring compromises between:

- o Providing the degree of protection the elderly need against the financial consequences of expensive illnesses.
- o The assistance provided to elderly beneficiaries against paying more than necessary for prescriptions and not receiving all benefits due.

- o Paperwork burden on patients, pharmacists and the Federal Government.
- o The proportion of program costs absorbed by administrative expenses.
- o The overall cost of the program.

In making these choices, it is important to concentrate on obtaining the most protection for the expenditure made. But to do this you may have to live with aspects of the program that are not ideal and do not guarantee fair treatment for each covered individual or for each pharmacy affected.

For example, a deductible of \$250 (in 1987) would eliminate payment for around 60% of the prescriptions used by persons over age 65 and a deductible of \$500 would eliminate all but around 20%. It would be very expensive to process the drugs for which no payment will be made. But then you face the dilemma of whether to base reimbursements on what beneficiaries actually spent for drugs or what they should have spent if they purchased prudently, i.e., from low cost pharmacies and utilizing low cost generic versions of the drugs. On the one hand, it is difficult to justify federal payment of higher prices than available in the market place. On the other, if the program only reimburses on the basis of government determined prudent prices, many patients will find their liability for out of pocket payments greater than the \$250 or \$500 deductible.

Of course, the Congress could take advantage of both the still substantial market share after a large deductible - and the publicity attending a Federal program - to provide assistance to elderly persons in purchasing drugs. For example, if the Federal Government recognized participating pharmacies and required them to charge no more than a prudent price to all Medicare beneficiaries (regardless of whether the purchase was being reimbursed by the catastrophic program), it is unlikely that many pharmacies would fail to participate, out of fear of losing patients or of a bad image.

But such use of the program to regulate pharmacy pricing for the elderly would also involve the program in a thicket of difficult issues concerning what constitutes prudent prices in different situations. For example, pharmacies with higher prices may provide additional services which may be needed by elderly patients, including accessible locations, delivery, record keeping, counsel and advice, etc. There are many parallels in this situation to the issues involved in reasonable charges and participating physicians in Medicare. The patients of physicians that do not accept assignments are reimbursed less than 60% of their bills rather than the 80% Part B was designed to pay. It would appear more likely that patients would change pharmacies than that they would change physicians over assignment policies.

I will try to illustrate these points with a few examples of prototype programs, which illustrate some of the many possible ways that prescriptions may be included in a catastrophic insurance program for Medicare beneficiaries.

4. Prototype Options

To illustrate the issues that must be addressed and the choices that must be made, three prototype programs are presented below.

A. Separate prescription deductible

One approach to including prescriptions in a catastrophic program would be to cover them subject to a separate annual deductible, such as \$250 or \$500. A variation of this approach would be to pay for 80% of expenditures for prescriptions beyond \$250 in a year with the maximum out of pocket limited to \$500 (reached when covered expenditures reached \$1500). With a \$250 deductible, payment would be made for around 40% of prescriptions, and with a \$500 deductible, payment would be made for around 20%.

One approach to administration of such a program would be to have participating pharmacies report all purchases to HCFA in a uniform, predesignated format. Data for a large proportion of prescriptions could be obtained in computer code. But this could mean complete processing for all prescriptions dispensed to Medicare beneficiaries, when reimbursement would only be made for a small proportion.

With a large deductible, it would be far more economical to limit processing to beneficiaries who will be eligible for some payment. This requires beneficiaries to collect the data required for their purchases and submit it for reimbursement. But many beneficiaries would not submit all of their prescriptions and all would have to pay first and obtain reimbursement later. In addition, there would be the prudent purchase price dilemma. Reimbursement must be based on either the actual prices paid by beneficiaries or on prudent prices. If the former is chosen, taxpayers will be paying more than should have been paid. If the latter, beneficiaries will not be equally protected.

Several measures, however, could be taken to minimize administrative expense and to reduce the burden on beneficiaries. For example, each Medicare beneficiary could be sent a booklet each year with spaces for pasting in labels prepared by the manufacturers showing the product, form and dosage and with the quantity, pharmacy ID, beneficiary SSN, and purchase price added by the pharmacist. Beneficiaries would then submit the booklets at year end to HCFA, and claims could be computed with optical or magnetic scanners.

Another possible approach would be to issue a special identity card to beneficiaries when they provide proof of exceeding the deductible. But several months may expire before they would receive it. Still, those beneficiaries with huge, chronic expenditures would benefit. Another approach would be to allow assignment to a pharmacy that has dispensed more than the deductible amount to the same patients. But keeping central records as is done for the Part B deductible would be very expensive and consume an excessive proportion of program dollars in administrative expense.

Administrative expenses would be minimized by promulgating a reimbursement level or formula for each possible combination of drug, version, form, strength and quantity that might be dispensed. This would produce a reimbursement level that at least on the average reimbursed beneficiaries who had been economical in their purchases of prescription drugs. (It must be noted, however, that the problems in compiling a fee schedule would be similar in many ways to those that have been encountered in implementing the "Estimated Acquisition Cost" and "Maximum Allowable Cost" allowances in the Medicaid "MAC" program.) The opposite approach would be to base reimbursement on what patients actually paid for prescriptions and to require pharmacies to charge no more than prudent prices.

B. Combined Catastrophic Program

A major problem with a separate prescription deductible is that Medicare beneficiaries are not equally protected against catastrophic out of pocket outlays. For example, a beneficiary who had required several hundred dollars of medicines in a year, but was not confined in a hospital and had to pay less than \$200 in Part B cost sharing (deductible and coinsurance for participating physicians) would receive some reimbursement, but another patient with much higher total out of pocket payments but less than the drug deductible for prescriptions, would receive none. This limitation can be overcome by making prescriptions an additional covered service reimbursed after a common annual catastrophic deductible has been reached.

For example, rather than cover the cost sharing in Part A and Part B subject to a catastrophic deductible of \$2000, there could be a deductible of around \$2250 for the sum of Part A and Part B cost sharing and expenditures for prescriptions. A deductible near this

level would produce a program with approximately the same cost. But beneficiaries would have better protection against the cost of large out of pocket expenditures, and program payments would be directed to those beneficiaries with the highest overall out of pocket expenses.

For example, suppose a beneficiary pays a hospital inpatient deductible of \$520, a Part B deductible of \$75, Part B coinsurance of \$1500 (on \$7575 of reasonable charges), and \$750 of allowable costs for drugs. With a \$2000 deductible, but no coverage of prescriptions, the reimbursement for this beneficiary would be only \$95. If drugs are included and the deductible raised to \$2250, the payment would be \$595.

With a common catastrophic deductible, most of the same problems must be solved concerning payment level and the administrative system. There is the additional problem that the correct reimbursement amount depends on eligible Part A and Part B cost sharing. This would require additional processing and delay payments for the portion of reimbursement that depends on prescriptions. As with a separate deductible, administrative expenses would be minimized by requiring the patients to pay first out of pocket and claiming reimbursement from HCFA. It might also be possible to issue an identity card to beneficiaries who had satisfied the deductible based on Part A and Part B cost sharing.

A variation of this approach would be to allow drugs to satisfy the catastrophic deductible, but not pay any reimbursement for them. This approach, however, would have all the administrative expenses and approximately the same overall cost as the option described above.

Another variation would be to pay for prescription drugs through the Medicaid program when the catastrophic deductible has been met. Most prescriptions would have to be reimbursed retroactively, however, since it would be difficult to inform the state Medicaid programs when Medicare beneficiaries had satisfied their catastrophic deductibles. There would not seem to be any major advantages to this approach except for those who are entitled to both Medicare and Medicaid benefits.

C. Catastrophic drugs only

Another option for covering prescription drugs under a Medicare catastrophic program would be to determine a list of drugs normally used only in connection with diseases that result in very large out of pocket expenditures. Coverage could be triggered by payment of a Part A inpatient deductible (\$520) or by a beneficiary meeting the Part B or both the Part A and the Part B deductibles. Payment might also be conditional on a hospital confinement with an appropriate DRG.

One problem with illness specific programs or "maintenance" drug programs is that the expenditures do not go to the beneficiaries with the greatest financial needs. Another problem is that many drugs that are normally used for chronic or expensive conditions can also be used for other conditions. Because they are reimbursed, physicians may prescribe them rather than more suitable drugs that are not reimbursed.

5. Impact of Catastrophic programs on deficit reduction

An important feature of a catastrophic program covering prescriptions that the Congress must understand is the rate of growth of expenditures from year to year. The large deductibles used to define catastrophic expense require that bills be accumulated before payment begins. Further delays will be encountered in processing claim data and making payments. Consequently, the first year of a catastrophic program will not be representative of the level of cost that will be encountered as the program matures. The cost of a catastrophic program cannot be judged by the first year expenditure.

In addition, expenditures under catastrophic programs will normally grow much more rapidly over time than the general rate of inflation. The problem is that expenditures for health care tend to grow at a faster rate than income or the CPI, a trend that has been going on at least since World War II. The deductibles used to define a catastrophic expense, however, are rightly adjusted by an index such as the CPI, which tends to grow at the same rate as average income and resources.

When the deductible is very large, however, a small difference in the rate of growth of expenditures over the CPI may produce a much larger rate of growth in program expenditures. Thus the outlays of a catastrophic program may increase at a rate several times the rate of general inflation, and make deficit reduction in future years correspondingly more difficult.

Chairman STARK. I have a feeling that Dr. Silverman wants to say something here.

Mr. SILVERMAN. You read my mind, Mr. Chairman.

Now that my distinguished colleagues have laid the groundwork, may I mention a few historical facts? It was 20 years ago this year that the Secretary of what was then HEW set up the HEW Task Force on Prescription Drugs on the orders of the President. It was to investigate the drug needs of the elderly and find out whether or not these needs could be satisfied under the Medicare program.

This assignment was turned over to Phillip Lee, who was then Assistant Secretary for Health, who served as task force chairman. I had the honor of being executive secretary and staff director. We thought we could handle this question over one long weekend. We were a little optimistic. It took us 20 months.

During that time, we investigated a large number of programs in this country and overseas. We came out with two important conclusions: first and foremost, that an out-of-hospital prescription drug program was needed by the elderly; and, second, that on both medical and economic grounds such a program would be feasible.

Since then, we have been looking at other programs in this country, in Australia, New Zealand, Canada, Japan, and about a dozen European countries. We looked at a number of programs in the United States. Every one of these out-of-hospital drug programs, Mr. Chairman, is flawed. Every one of them has weaknesses. Every one of them is under constant criticism. But if any one of those should be thrown out, I am convinced that blood would flow in the streets the following afternoon.

In setting up a program, it is important to keep a few numbers in mind. First of all, according to the Consumer Price Index, the index for out-of-hospital drugs has gone up from 100 in 1967 to 281 last December. In the same period, the price for a physician's services has gone up from 100 to 442. The CPI for hospitals has gone up even faster than airplane travel. It has gone up to 780.

Twenty years ago, the average cost of an out-of-hospital prescription was about \$3.50. It was about \$4 for the elderly. Today it is closer to \$13.60. The per capita use of out-of-hospital drugs by the elderly was only about \$50 20 years ago; now, it is about \$250.

The fact is that too many of the elderly, those 65 and older, have costs for drugs which they cannot afford. As a result, they get inadequate or insufficient drug treatment, and they pay for it by needless hospitalization and needless surgery.

Let me give you one example. We know today that some of these so-called beta blockers can relieve the dreadful incapacitating pain in heart disease with angina. The only current alternative to drug therapy today is a coronary bypass operation. Last week, I was able to get at least a rough approximation of what such surgery would cost from my neighborhood hospital. I found out that the price for a triple bypass would involve about 7 to 10 days of hospitalization at \$3,000 a day, or about \$25,000; a surgeon's bill of \$5,500 for a Medicare beneficiary, about \$2,200 for two assistants at \$1,100 each; and \$2,000 for the anesthetist. That totals \$34,700, and I am not sure I included bills for X-rays, laboratory tests, and in-hospital drugs.

It is difficult to understand how Medicare will pay that kind of a bill and yet not pay for the out-of-hospital drugs that could make surgery unnecessary. These drugs have a price tag of about \$0.50 to \$1 a day.

Once again, it seems that we are coming to grips with this whole challenging problem of out-of-hospital drugs. Every effort must be made to achieve certain objectives. The primary goal must be improved health, and the quality of health care must not be needlessly sacrificed merely to save money.

Costs of any national drug program must nevertheless be kept at reasonable levels. Patients must be given protection against the catastrophic costs of illness. The program must aim for simplicity with a minimum of rules, regulations and especially paperwork. Pharmacists must receive reimbursement for not only their goods but also their services. The drug industry must not be deprived of incentives to support productive and innovative research.

Wherever possible, patients must take part in the decision-making process which concerns which drug they will take or which drugs they will not take and how they are going to take them.

In designing any program for covering out-of-hospital prescription drugs, a number of decisions must be made. And as Mr. Trappnell points out, some of these are going to be very painful. These, I trust, we can discuss in the minutes yet to come.

Thank you, Mr. Chairman.

Chairman STARK. Thank you.

Let me just make a couple of comments, and I will ask each of you to comment on them.

It seems to me that if we are going to pay anything out of the Medicare system, we are going to have to have some Medicaid type cost containment program. And I suspect they work. In other words, I suppose that if we insist on some kind of plan for generics, low prices for brands and some kind of a payment to dispensing pharmacists who will keep the records, we will keep costs down for everybody.

As I see it, a whole lot of people pay under a couple hundred dollars a year. And while that may not be generally catastrophic, it is burdensome. And a catastrophic bill that required the cost reducing functions would bring that cost down for those people in the under \$200 a year category almost by definition.

There are very few who pay over \$1,000 a year for drugs. Certifiable, \$500 to \$1,000 is catastrophic particularly for the low-income people.

We could get at that with \$2 billion. As long as Mr. Gradison and Mr. Donnelly are out of the room, we can get the \$2 billion by making State and local employees pay their fair share of Medicare costs.

So let us suppose that the hassle we get from the various pharmacists and the various pharmaceutical manufacturers notwithstanding, that we have got the \$2 billion and we put a \$200 deductible, a \$3 copayment, a Medicaid type cost containment program, MAC for generics, wholesale price for branded products, and a dispensing fee for the pharmacist. Admittedly, there are all kinds of variations on that, but is that worth the effort for us to try and do

it in this bill? Or would you all say forget it and come back when you can do something better or different?

Who wants to comment on those two assumptions: first, that cost containment will in itself benefit a lot of people just by holding some costs down; and, second, that if this is the best we can do, if we had the money—and it is probably very linear. So if we only had \$1 billion, we would just do about half as much.

Would you all say that is worth striving for in this bill?

Mr. SILVERMAN. I think it makes a good start, Mr. Chairman, but only a start. I think other factors have to be considered, considered very carefully. Among others is the use of a formulary. This has been a matter of great concern and heated debate.

There are a number of my friends who feel that there must be a compulsory national formulary. If this is instituted, I think it would be a total disaster. Instead, attention must be given to national guidelines or a national voluntary formulary.

Chairman STARK. I think I agree with you, Dr. Silverman. My only concern is the politics of it. It is my understanding the pharmaceutical manufacturers would oppose that.

Mr. SILVERMAN. That would not surprise me. And I think most physicians would oppose it.

Chairman STARK. We recognize that and I am sure the witnesses do. The question is, if you do not fight that battle first, do you lose it forever? We certainly lost it in participating physicians. They were able to keep that out in 1965, and they have defeated any decent improvement since.

Now, maybe that is the reason. We should not do it unless we can do it right.

Commissioner Sabol, what is your feeling?

Ms. SABOL. I concur with Dr. Silverman that indeed it would be an excellent start. I'd like to go back, however, and just underscore the point that you were making about cost savings for everyone. I think there has been experience in New York, that generic drugs, when put in place—and we think the DAW dispense's written proposal will broaden that even further—will indeed have an impact on all elderly in terms of reducing out-of-hospital prescription drugs, and for the nonelderly as well.

So I think the use of generics is an important part of that whole cost-containment strategy.

The other issue that I would raise that probably needs to be considered should such a program be implemented, is that consideration be given to some kind of drug utilization review program. That issue should be examined and considered right up front as part of the implementation of any proposal.

But I certainly concur that it would be an excellent beginning.

Ms. SCHAPIRO. If I may add to that.

Chairman STARK. Please. Would you identify yourself?

Ms. SCHAPIRO. I'm Mildred Schapiro from New York State. I think if we have a MAC program, as I think we should, I think there should be a commitment to it by whatever department is implementing it, so that you have a constant updating. There have been very significant patents coming off, and these are opportunities for multisource generic drugs. That should constantly be expanded.

I also think there should be control of new drugs. While I'm not proposing a formulary, there are such innovations in the pharmaceutical manufacturing industry with "me-too" drugs and combination drugs, and I would love to use the Medicare program if it afforded this additional benefit as a way of getting their new marketing going. And I think just as we in New York State control and have petitions every time there is something new, we wait until something is medically accepted in the marketplace before we add it to the list.

So whatever you have, I think you need some kind of a screening mechanism to control that flood of new innovations coming out of the industry.

Chairman STARK. Mr. Trapnell, is this catastrophic enough and do you agree that the benefits will trickle down to the lower-income, noncatastrophic type patient?

Mr. TRAPNELL. I would rather comment on the cost proposal along the lines of the one that you described.

Chairman STARK. OK.

Mr. TRAPNELL. About a year and a half ago I did some estimates for the Villers Foundation in which they requested that I estimate a proposal very similar to the one that you suggested, including a \$200 deductible. This program would begin with a \$200 deductible in 1987, and a \$3 copayment; and it would increase that deductible and copayment each year at the rate that the CPI goes up.

However, because of the lags in payment when you accumulate drugs to a deductible, and then submit them for payment, the cost doesn't reach an ongoing cost level until at least the second year, and, because of the deductible, it tends to grow more rapidly than the cost of prescriptions from year to year.

These estimates were that the program would cost about \$1.2 billion in 1987, about \$2.6 billion in 1988, about \$3.1 billion in 1989, and reach \$3.8 billion by 1990. So you see the rapid rate of increase because of the leverage that the deductible has.

Chairman STARK. Thank you very much. As I say, it's difficult for us to determine, with all the factors that create a financial catastrophe, just which way the committee may go as it attempts to expand the benefits, and that's always a difficult decision.

Dr. Silverman, did you want to add something?

Mr. SILVERMAN. There are two other factors that I think the committee should consider with great care. The pressure on prescribing or dispensing low-cost, high-quality generic drugs is very important. But this will not solve the problem of the single-source drug, the drug which is still on patent. And at least in theory the manufacturer of such a drug, particularly one of life-saving qualities, can hold a gun to the Government and charge any price that it wants.

Accordingly, I think the Government should take a very careful look at purchase of these drugs by the Government at a reasonable price set by the Government and, if necessary, hashed out in the courts. The legal authority for this is already on the books, although not too many people seem to know about it. I think it's 28 U.S.C. 1498.

Another approach which deserves consideration is the implementation of required cross-licensing, as our friends in Canada have been doing with great effect for the last several years.

And, again, as Commissioner Sabol pointed out, it is imperative that any such program be equipped from the outset with effective automatic data processing. Without this it is impossible to apply utilization review, and without utilization review the whole thing will crash.

Thank you, Mr. Chairman.

Chairman STARK. Thank you. Thank you all very much for very informative testimony.

Our next panel will discuss mental and dental health benefits for the elderly: Hilda Robbins, the past president of the National Mental Health Association; Dr. Steven Sharfstein, the vice president and medical director of the Sheppard and Enoch Pratt Hospital in Baltimore; Dennis Gilbride, the director of Mental Health Cost Containment Services of Intracorp, Wayne, Pa.; and Dr. Larry Meskin, who is dean of the School of Dentistry at the University of Colorado in Boulder.

I'd like to welcome the panel, and again repeat that your prepared testimony has been distributed to us, and, without objection, will appear in the record in its entirety. And we'd ask you to expand on or summarize your written testimony in any way that you are comfortable.

Ms. Robbins?

STATEMENT OF HILDA ROBBINS, PAST PRESIDENT, NATIONAL MENTAL HEALTH ASSOCIATION, ALSO ON BEHALF OF THE MENTAL HEALTH LAW PROJECT, AND THE NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS

Ms. ROBBINS. Thank you very much. We appreciate very much the fact that the committee is giving this time to consider the special characteristics of coverage in catastrophic insurance for the mentally ill. My name is Hilda Robbins—you have this in your distributed testimony—and I live in Fort Washington, Pa. I've been a volunteer with the Mental Health Association for over 30 years, and I've also been a consumer of mental health services for over 40 years, having been subject to deep and debilitating depressions since I was a teenager.

Today I represent not only the Mental Health Association but the Mental Health Law Project. The Mental Health Association has been speaking for consumers of mental health needs since 1909. The Mental Health Law Project has been in existence for the last 14 years, protecting the rights of the mentally ill.

This testimony that I give today is designed to illustrate how the Medicare program, title XVIII of the Social Security Act, which was created by Congress to assist that part of the population which is 65 years and over and people who are unable to work because of physical or mental impairments, discriminates against one specific segment of that population, the mentally ill, and to urge members of this committee to take the initiative in ending that discrimination.

Medicare mental health policy encourages institutional care, it discourages early intervention, and it fails to cover the types of services which research shows are the most effective in keeping individuals out of hospitals and functioning at their optimum level. Now, why should this be so? In part it's just an accident of history in that when Medicare was first enacted 20 years ago our attitude about mental illness and treatment was significantly different. But while we have made enormous strides in the treatment of mental illness over the last 20 years, the Medicare mental health benefits have never once been revised.

I want to discuss, first, some basic statistics. For instance, 15 to 25 percent of elderly persons experience significant mental health problems; 20 percent of all reported suicides are by persons over 65, and the death rate from suicide among the elderly is one and a half times the rate for all ages; estimates of the over-age-65 population who are afflicted with Alzheimer's disease range from 4 to 15 percent.

Among the 3 million disabled people on the Social Security disability rolls who are receiving Medicare benefits, an estimated 11 percent are mentally ill, or 300,000 people. If you are familiar with the standards for determining mental impairment used by Social Security, you know that these 300,000 souls are severely and permanently disabled to the point that any gainful employment is impossible.

But despite the obvious need for mental health services for elderly disabled people, Medicare discriminates against people with mental illness, not through administrative or arbitrary regulatory policy drawn up by the bureaucracy at HHS, but through the very language that's written into the law of title XVIII.

Hospital insurance provides a maximum of 150 days each time a person enters the hospital. The beneficiary may return to the hospital as many times as necessary for the rest of his life as long as there is a break between hospital stays, and still be covered by Medicare. However, if he is a patient in a psychiatric hospital, this is totally different. If the beneficiary is a patient in a psychiatric hospital rather than a general hospital, there is a lifetime limit of 190 days coverage under Medicare. Moreover, if the beneficiary is a patient in the psychiatric hospital, at the time he becomes eligible for Medicare, the number of days that he has already spent in the hospital is deducted from this initial benefit period. No such deductions are made against a patient who happens to be in a general hospital when Medicare coverage begins.

There is no alternative plan under part B for supplemental Medicare insurance. Part B of Medicare provides that for those who choose to subscribe, the Government will pay 80 percent of allowable doctor bills and related noninstitutional expenses. Once the deductible has been met, there is no limit to the amount of reimbursement in any one year, unless the diagnosis is mental, psychoneurotic, and personality disorder—in other words, mental illness. If the diagnosis is mental illness, the absolute maximum reimbursement in any one year is \$250. This maximum, in addition to being discriminatory in itself, is also calculated in a discriminatory fashion. What this means is that for all other illnesses, Medicare

pays 80 percent after deductible. But for mental illness it pays only 50 percent.

There are other policies and practices which discourage appropriate treatment. Services, when furnished through a provider other than a hospital, are not reimbursable. Services of a rehabilitative nature are not covered at all, despite their proven effectiveness. Outpatient prescription drugs are not covered when the cause of a major problem is serious mental illness. These people have tremendous expenses from psychotropic drugs to combat hallucinations and other active symptoms of their illnesses.

There has been some flexibility within the last few years which allows physicians to bill for medical service to patients with Alzheimer's disease without regard to a limit on mental health care, although psychotherapy for these patients is still limited to the \$250 limit. As evidence has increased for the biological base of many mental illnesses, the argument for a further expansion of mental illness treatment similar to Alzheimer's seems to be strengthened. Mental health centers have benefitted from the "incident to" rule which authorizes services, without regard to the \$250 limit—psychologists, psychiatrists, psychiatric nurses and social workers, when providing services which are incident to a physician's services, can be reimbursed.

Because Medicare fails to provide adequately for the needs of elderly and disabled Americans with mental illnesses, the public has to pay in other ways. Elderly people, for example, occupy 30 percent of all public mental hospital beds, and very conservative estimates place the percentage of nursing home residents with a primary or secondary diagnosis of mental illness at 70 percent. Many of these individuals are inappropriately placed in these institutional settings. Another 10 to 20 percent of those already in nursing homes might be suitable for community placement if there were extended services.

There are estimates that 25 percent of elderly persons determined to be "senile" actually have treatable and totally reversible mental health conditions. Much is made of the fact that Medicare covers only 45 percent of the elderly's average health care. We should realize that for mental health care services, this percentage is significantly lower.

Catastrophic illness is viewed as a serious, unexpected, and costly illness which results suddenly with a heavy financial burden.

Chairman STARK. Ms. Robbins, I'm going to ask you to suspend here for a moment. As you know, we can read faster than we can speak, and we will get back to many of the items covered in your testimony in our inquiries. I'm going to ask Dr. Sharfstein to proceed—if he can, to expand or summarize his testimony.

Ms. ROBBINS. With all due respect, I would like an opportunity, before we close out this panel, to give the summary of our recommendations.

Chairman STARK. A summary would be very much in order. The testimony will be read by many, including myself. But there are some questions that I'd like to ask. So, if you will pardon the interruption, I will ask Dr. Sharfstein to proceed.

[The prepared statement follows:]

Statement of Hilda Robbins, on Behalf of
the Mental Health Law Project, National
Association of State Mental Health Program
Directors, and the National Mental Health
Association

My name is Hilda Robbins. I live in Fort Washington, Pennsylvania. I have been a volunteer with the mental health association at all levels-- local, state, and national -- for going on 30 years. In 1979, I was President of the National Mental Health Association, and am currently Regional Vice President for North America for the World Federation for Mental Health. I have been subject to and treated for depression for over 40 years. I am testifying today on behalf of the NMHA, the Mental Health Law Project and the National Association of State Mental Health Program Directors.

The National Mental Health Association (NMHA) is a non-governmental, citizen's voluntary organization concerned with all aspects of mental disorders and mental health. It was founded in 1909 by Clifford Beers, who suffered from a serious mental illness. After his recovery, Beers spent the rest of his life creating a nationwide organization whose members would protect the rights of people with mental illnesses, educate the public about mental health and illnesses and promote research into the causes, prevention, treatment and cure of mental disorders. Beers also founded the World Federation of Mental Health. NMHA now has a network of 650 local chapters and state divisions which provide programs tailored to the needs of their community.

The Mental Health Law Project is a non-profit, public interest organization whose principal goals over the past 14 years have been to bring mentally disabled people under the full protection of our nation's laws and to establish access for them to suitable health care, education, social services and housing.

This testimony is designed to illustrate how the Medicare program, Title XVIII of the Social Security Act, created by Congress to assist that part of the population which is 65 years of age and over and people who are unable to work because of physical or mental impairments, discriminates against one specific segment of that population, the mentally ill, and to urge the members of this Committee to take the initiative in ending that discrimination.

Medicare mental health policy encourages institutional care, discourages early intervention, and fails to cover the types of services which research shows are most effective at keeping individuals out of hospitals and functioning at their optimum level. Why should this be? In part, this is an accident of history, in that when Medicare was first enacted twenty years ago our attitude about mental illness treatment was significantly different. But while we have made enormous strides in the treatment of mental illness over the last twenty years, Medicare mental health benefits have never been revised.

The current interest in catastrophic insurance allows us to re-examine mental health benefits under Medicare from the perspective of those elderly and disabled people who are spending considerable resources on health care. We also urge the Committee, in the not too distant future, to re-examine basic Medicare mental health benefits for all.

Prevalence of Mental Illness Among Elderly and Disabled

Before discussing in more detail the inadequacies of Medicare coverage, let me first give you some basic statistics. You are well aware how the elderly population is growing. As the over-age-65 population increases to 50 million people over the next fifty years, remember that the costs of mental illness, given the prevalence rates I am about to give you, will increase proportionately:

- * Fifteen to twenty-five percent of elderly persons experience significant mental health problems;

- * 20% of all reported suicides are by persons over age 65 and the death rate from suicide among the elderly is 1 1/2 times the rate for all ages;

- * Estimates of the over age 65 population who are afflicted with Alzheimer's disease range from 4-15%.

Among the three million disabled people on the Social Security Disability rolls, who also receive Medicare benefits, an estimated 11% are mentally ill--300,000 people. And if you are familiar with the standards for determining mental impairment used by the Social Security Administration, you know these 300,000 souls are severely and permanently disabled to the point that any gainful employment is impossible.

Medicare Coverage for Mental Health Services

Despite the obvious need for mental health services for elderly and disabled people, Medicare discriminates against people with mental illness, not through administrative or arbitrary regulatory policy drawn up in the vast HHS bureaucracy, but through the language written into the law--Title XVIII of the Social Security Act as passed by Congress in 1965.

Under Part A, hospital insurance, the beneficiary is covered for a maximum of 150 days each time he or she enters a hospital. The beneficiary may return to the hospital as many times as is necessary for the rest of his life, as long as there is a break between hospital stays, and still be covered by Medicare--unless he or she is a patient in a psychiatric hospital. If the beneficiary is a patient in a psychiatric hospital rather than a general hospital, there is a life-time limit of 190 days of coverage under Medicare. Moreover, if the beneficiary is a patient in a psychiatric hospital at the time he becomes eligible for Medicare, the number of days he has already spent in the hospital is deducted from his initial benefit period. No such deduction is made against the patient who happens to be in a general hospital when his Medicare coverage begins.

Because coverage in a psychiatric unit of a general hospital does not fall within the 190-day lifetime limit, mentally ill Medicare beneficiaries have an optional source of treatment. There is, however, no similar alternative under Part B, supplemental Medicare insurance. Part B of Medicare provides that, for those who choose to subscribe, the Government will pay 80 percent of allowable doctor bills and related non-institutional medical expenses after a deductible. Once the deductible has been met, there is no limit to the amount of reimbursement in any one year--unless the diagnosis is "mental, psychoneurotic, and personality disorder", in other words, mental illness. If the diagnosis is mental illness, the absolute maximum reimbursement in any one year is \$250.

This maximum, in addition to being discriminatory in itself, is also calculated in a discriminatory fashion. Part B of Title XVIII states that the allowable cost for treatment of a "mental, psychoneurotic, and personality disorder" shall be only 62 1/2 percent of actual costs. What this means is that for all other illnesses Medicare pays 80 percent after the deductible, but for mental illness pays only 50 percent (80 percent of 62 1/2 percent) and then only up to a ceiling of \$250.

In addition, there are other policies and practices which discourage appropriate treatment. For instance, hospital-based partial hospitalization services (day treatment or overnight care) are covered, but the same services when furnished through a provider other than a hospital are not reimbursable. Services of a rehabilitative nature are not covered at all, despite their proven effectiveness in maintaining seriously mentally ill individuals in the community and avoiding expensive hospital care. Outpatient prescription drugs, as you know, are not covered which causes major problems for seriously mentally ill people who must have expensive psychotropic drugs to combat hallucinations and other active symptoms of their illnesses.

Medicare policy does, however, permit some flexibility within these limits. For example, a recent change in Health Care Financing Administration policy allows physicians to bill for medical services to patients with Alzheimers disease without regard to the limit on mental health care, although psychotherapy for such patients is still subject to the \$250 limit. As evidence gathers of the biological base of mental illnesses (such as the recent identification of the gene associated with manic-depressive illness) the arguments for further expansions of mental health treatment similar to this Alzheimers coverage are strengthened. Furthermore, patients using organized community settings, such as community mental health centers, have benefitted from the "incident to" rule, which authorizes services (without regard to the \$250 limit) of nurses and other health professionals when furnished incident to

services of a physician. Under this rule, current Medicare policy allows reimbursement of psychologists, psychiatric nurses and social workers when provided incident to a physician's services. Community mental health centers and other organized care settings have used this rule to provide essential treatment to elderly and disabled clients, although the physician service remains subject to the Part B limit.

However, these policies, while they permit coverage of certain mental health services, do not begin to compensate for the basic thrust of the program which is to cover inpatient general hospital care, and such marginal, traditional and limited outpatient psychotherapy as to be nearly useless.

Consequences of Medicare's Inadequate Mental Health Coverage

Because Medicare fails to provide adequately for the needs of elderly and disabled Americans with mental illnesses, the public has to pay in other ways.

Elderly people, for example, occupy 30% of all public mental hospital beds and conservative estimates place the percentage of nursing home residents with a primary or secondary diagnosis of mental illness (including dementia) at 70%. Many of these individuals are inappropriately placed in these institutional settings.

The State of Minnesota has recently estimated that a majority (89%) of its elderly citizens with a diagnosis of mental illness are living in nursing homes. The state further estimates that approximately 30% of these people could have avoided nursing home care if sufficient community support were available. Another 10-20% of those already in nursing homes might be suitable for community placement with extended services. Presuming that Minnesota is not atypical, revised Medicare policy which encouraged early intervention and appropriate community services could reduce institutional costs, particularly under Medicaid, while greatly enhancing the quality of life for those now institutionalized.

Lack of money and Medicare coverage also leads people to forego needed care. For example, there are estimates that 25% of those elderly persons determined to be 'senile' actually have treatable, reversible mental health conditions. The elderly poor without other insurance also average only 4.2 physician visits and 8.7 prescription drugs a year compared to 6.5 physician visits and 12.2 prescription drugs for the elderly who have Medi-gap insurance. Much is made of the fact that Medicare covers only 45% of the elderly's average health care bill. For mental health care services, this percentage is significantly lower.

Therefore, I urge the Committee to re-examine basic Medicare coverage so as to improve mental health benefits for all elderly and disabled individuals in the not too distant future. However, my testimony this morning focuses on catastrophic coverage.

Catastrophic Health Insurance: Who Should be Covered?

Frequently, discussions of "catastrophic" insurance and catastrophic illness focus on acute health care services. Catastrophic illness is viewed as a serious, unexpected, and costly illness which results in a sudden, heavy, financial burden. While this is an accurate perception for many people, including people with mental illness facing the need for intensive acute care hospital or outpatient treatment, it ignores the realities of individuals disabled by serious health and developmental disabilities, such as schizophrenia, depression, mental retardation or cerebral palsy. As organizations representing consumers, we are well aware that for many Americans, long term mental illness is a "catastrophe" in progress.

We do not believe that bills introduced in Congress to date adequately address the service needs and catastrophic impact of long-term disabling conditions. As this Committee studies the issues of catastrophic illnesses, it is important that you not repeat the discrimination of the past. Medicare's restrictions prevent both elderly individuals with acute problems, and elderly and disabled people with serious and chronic mental illnesses from receiving care in the most appropriate settings. The result has been unnecessary, costly, and restrictive forms of inpatient, skilled nursing facility, or

intermediate care facility arrangements. We must look at all these issues in enacting a catastrophic health plan.

If viewed in a broad context, "catastrophic illness" should include all disabling conditions with their multi-year financial drain on consumers and families. Also, "catastrophic costs" can result from inappropriate use of expensive services resulting from a failure to provide adequate coverage for early interventions and less intensive community-oriented services.

Lack of reimbursement also hampers the development of services, so that in many parts of the country the services individuals with mental illness need are simply not available.

I urge the Committee to view catastrophic health care issues in these broad terms.

Long-Term Mental Illnesses

Schizophrenia and affective disorders, such as depression, are two types of mental illnesses that for most are lifelong in nature. Schizophrenic disorders, although only affecting one percent of the adult population (or approximately 1.5 million people), results in clinical conditions with the highest social disability. Affective disorders, manic-depression and depressive disorders, affect another 9.4 million adults. Alzheimers disease affects approximately 1 to 1.5 million elderly persons. Of the 3 million people current on the Social Security Disability Insurance program, approximately 11% are mentally disabled.

Although the mental health services system provides a range of care to meet the needs of this vulnerable population, the types of services needed by both elderly and younger individuals with major mental illness are often not covered. Medicare limitations make coverage totally inadequate for individuals facing the catastrophe of long-term mental illness, and fail to recognize the range of services needed by persons with a complex and long-term illness. Medicare will not pay for care in certain settings which are most appropriate for this population and also emphasizes medical services to the exclusion of vital rehabilitation services that can prevent relapses.

For the individual with a chronic, disabling condition, day rehabilitation programs provide an appropriate service. In these programs, clients can be assisted to re-learn or learn the essential skills of everyday living which they need to function in the community, as well as continue to receive necessary medications and medications monitoring. An essential function of these programs is case management, to ensure that clients are receiving the health, mental health and related services that they need.

Long term psychosocial rehabilitation services, and case management have proven successful in helping clients to live and work in society, despite relapses, and is more cost effective than hospitalization. Thus, the Medicare bias towards hospitalization is an inappropriate allocation of funds that could be used more efficiently in outpatient mental health services.

Acute Mental Health Care Needs

The stringent restrictions on outpatient mental health coverage make even treatment of acute mental health problems problematic. For acute care, an important aspect is early intervention. Research shows that a substantial proportion of patients can be treated in twenty visits or less, and that copayments are a deterrent to seeking care. Yet Medicare coverage is limited to somewhere between 6-9 visits a year, with high copayments.

Many patients in need of outpatient mental health services inappropriately use other Medicare benefits, thus costing the system unknown amounts in other expenditures. Psychiatric and mental health interventions have been shown to reduce the use of other medical and surgical services. By ignoring and failing to treat the patient's mental health needs we do not eliminate those needs, they merely show up in other ways as patients report physical symptoms

resulting from undiagnosed mental stress. There have been numerous studies of the cost-offsets achieved by providing mental health services, most notably:

- * A quantitative review was made by Mumford et al. of 34 controlled studies of the effects of psychological interventions on recovery of persons who had recently suffered a heart attack or were facing surgery. The data showed these interventions producing large effects in terms of speeding recovery, decreasing requirements for analgesic and sleeping medication, and shortening hospital stays.
- * A study of Blue Cross- Blue Shield federal employees program found that after a diagnosis of a chronic medical disease, those patients who began psychotherapy used 56% less medical services than a group with the same disease who didn't receive therapy. The savings are usually in hospital costs: preventing hospital admissions or shortening stays.
- * A review of the effect of psychotherapy on utilization of other medical care showed the average effect to be a reduction in utilization of 20%.
- * A study of psychiatric intervention in the postoperative course of elderly female patients requiring surgery for fractured hips showed that psychiatric consultation and liaison services led to a dollar benefit of almost 200,000 dollars over the cost of the psychiatrist in one year.
- * A series of cost-effective studies begun in the 1950s in West Germany was critical in persuading the national health insurance system in that country to include a 250 visit outpatient mental health benefit with a system of prospective approval and peer review.

Recommendations:

NMHA and MHLF recommend that the Committee examine all costs of mental illnesses in light of the needs for both acute care services for elderly individuals with a single, treatable episode of illness and for those elderly or disabled people who have a chronic illness. We urge you to view chronic and disabling conditions, including the major mental illnesses, as catastrophes in and of themselves. Individuals suffering from these disabilities will have significant, frequently lifelong needs for services, the costs of which add up very quickly to devastating amounts for patients and their families. A narrow view of catastrophic insurance which considers only out-of-pocket costs per year, does not address the needs of these populations.

A range of health care, including rehabilitative services and supportive care services, must be available through Medicare so that patients have access to the continuum of care which they need, and so that the most cost-effective services can be provided.

Specifically we recommend:

- * For individuals who reach the trigger point regarding Part B expenditures, as defined in legislation, all limitations on currently covered outpatient mental health services should be lifted. This would place the mentally ill beneficiary on an equal level with all other beneficiaries.
- * That the Committee ensure that the provision which eliminates limits on general hospital inpatient care for those who reach the trigger point continue to include individuals with a diagnosis of mental illness.
- * Expanding services for individuals who reach the trigger point, include under catastrophic coverage the following additional mental health services: partial hospitalization, psychosocial rehabilitation, case management and psychotropic medications.

Without these changes, persons experiencing the catastrophe of mental illness will continue to be denied the services they need to live healthy, productive lives. How can we justify denying some of the most vulnerable people in our society this opportunity?

Thank you for your concern with the needs of aged and disabled people who have mental illness.

**STATEMENT OF STEVEN S. SHARFSTEIN, M.D., VICE PRESIDENT
AND MEDICAL DIRECTOR, SHEPPARD & ENOCH PRATT HOSPITAL,
BALTIMORE, MD**

Dr. SHARFSTEIN. Thank you, Mr. Chairman. My name is Steve Sharfstein, I'm a psychiatrist. I'm the medical director of a private mental hospital just outside of Baltimore. I spent 13 years in the Public Health Service working for the National Institute of Mental Health, and the past 3 years with the American Psychiatric Association, very concerned about the economics of mental health care.

Mental illness is a severe medical condition and a real human tragedy and can be financially catastrophic and therefore appropriate for the true purposes of insurance.

The catastrophic gaps in Medicare allow now a historic opportunity for the elderly and other Medicare beneficiaries with mental illness to receive coverage for appropriate care. We can redress 20 years of discriminatory coverage and gaps in the Medicare program. In particular, outpatient care should be improved, the overall cap should be increased—the \$250 cap instituted in the late sixties is worth \$57 today. And the precedent set by the Department of Health and Human Services to exempt medical management for Alzheimer's disease from this \$250 cap should be given serious consideration for extension to all Medicare beneficiaries with every mental diagnosis. In addition, the 190-day limit on psychiatric hospital should also be eliminated. It is much better to manage longer term inpatient care through concurrent utilization review and preadmission certification than with arbitrary lifetime and yearly caps.

I would like to just describe to you for a minute the experience that I had a couple of months ago in admitting a 73-year-old patient to the hospital that I direct. I was her psychiatrist. She came in with an acute mania; she was quite psychotic and delusional, and had created quite a bit of havoc for her family. She had many concerns and many were really quite bizarre, and it was difficult to talk with this lady. However, one of her concerns was a financial concern. This lady was not so psychotic that she wasn't concerned that her Medicare was not going to cover the hospitalization that she was about to embark on, and was very concerned about what were the potential gaps in her coverage.

To add the worry of financing to the tragedy of mental illness was difficult not only for her but for her entire family. She responded very nicely to 2 weeks of inpatient care with a combination of psychopharmacology, notably lithium and other psychotropic drugs, and psychosocial treatments. She was discharged and needs outpatient followup. She should be seen weekly; she should have monthly lithium levels. She may need additional inpatient care because she has a relapsing illness.

Medicare can and should cover these expenses. Thank you.

[The prepared statement follows:]

STEVEN S. SHARFSTEIN, M.D.
VICE PRESIDENT AND MEDICAL DIRECTOR
THE SHEPPARD AND ENOCH PRATT HOSPITAL

Mr. Chairman, I am Steven S. Sharfstein, M.D., Vice President and Medical Director of The Sheppard and Enoch Pratt Hospital in Baltimore, Maryland, a nonprofit psychiatric health care facility which provides inpatient, day treatment, outpatient and community mental health services including several specialized programs for the elderly. I am also Clinical Professor of Psychiatry at the University of Maryland. I appear before the Committee representing only myself—a clinician, administrator, and researcher on the economics of mental health care. I have published over 75 papers and six books on a broad range of subjects related to the public and private financing of mental health services to all Americans.

My testimony will focus on the current impact of the Medicare program on opportunities for treatment of mental illness for Medicare beneficiaries. I will especially focus on the mental health needs of the elderly and other Medicare recipients, the catastrophic nature of some mental illness, and the need for full consideration of catastrophic coverage; that is, the amount of care which applies toward the catastrophic threshold as well as the coverage beyond that for the treatment of severe mental illness. I will also comment on the effective use of cost containment mechanisms which emphasize preadmission certification and concurrent utilization review as an alternative to arbitrary limits on psychiatric benefits.

The Current Medicare Coverage of Mental Illness – Disincentives for Cost Effective Care

Since 1965, the Medicare program has provided an opportunity for the elderly and other beneficiaries to receive psychiatric care as inpatients in general hospitals with the same restrictions and limitations as other medical conditions, but has restricted psychiatric care to 190 days during a patient's lifetime in a psychiatric hospital and limited outpatient care to an effective \$250 per year. These limitations have allowed for the inpatient treatment of acute severe illness, but have denied treatment for patients with intermediate and longer-term needs as well as patients who could be effectively managed outside of the hospital. Medicare spends approximately 2 percent of its total health outlays on the treatment of mental illness, and approximately 5 percent of the total mental illness treatment expenditure go for outpatient care. This contrasts with estimates that the treatment of mental illness represents 9 percent of the total health expenditures, and that people over 65 who make up 11 percent of the population account for 30 percent of all medical costs.

The mental health care needs of the elderly are not being met by any standard of evaluation. The elderly receive as much as half of total prescriptions for tranquilizers and barbiturates in addition to the over-the-counter analgesics and sedatives they buy. The suicide rate for older white males is higher than for any other age sex category. The elderly suffer multiple assaults to their self-esteem and losses associated with the aging process, such as death of a spouse, loss of a close friend, loss of financial status, dislocation of residence, and serious physical illness. Yet people 65 and older receive only 7 percent of inpatient psychiatric services, 6 percent of community mental health services, and 2 percent of services delivered in private psychiatrists' offices.

It is the poor financial access due to the limits in the Medicare program which deny the elderly needed treatment, and it is those who suffer from longer-term illness requiring more extensive inpatient diagnostic workups and more extended hospital stays and the need for long-term outpatient services who suffer the most. The data that the elderly are underserved is undeniable, and the Medicare restrictions reinforce a gloomy perception that not much can be done for the emotional distress of older persons, that all senility is irreversible, and that treatment is not worth the cost for someone who is no longer in his or her most productive years. The Medicare program sets in motion a self-fulfilling prophecy in which few services are offered to older people and very few older people are benefited from effective care.

Studies have shown that between 20 to 30 percent of the elderly who have been diagnosed with a dementia have an reversible, treatable condition if there is access to diagnosis and treatment. Depression which has a high prevalence among people 65 and over is an extremely treatable illness. But clearly, it is the limitation on outpatient psychiatric care that provides the biggest disincentive for the appropriate use of mental health services. The Department of Health and Human Services initiated the sole change in the Medicare program's outpatient benefit which occurred for treatment of Alzheimer's Disease and related disorders in 1984. Medical management, including diagnosis, supervision and monitoring of medication and associated side effects, is excluded from the effective \$250 annual limitation. Psychotherapy is still subject to the limitation.

The limitation on outpatient care forces the use of more expensive inpatient treatment. At the present time, if an elderly patient walks into my office with some memory difficulties, low energy, insomnia, and anxiety about "going senile," unless they

have substantial capacity to pay out-of-pocket, I must recommend a hospital stay in order to adequately do a diagnostic workup. If the patient develops a severe and relapsing depression after psychiatric benefits are exhausted, I am forced to refer the person to the state mental hospital nearest to their home.

Further, the limitations on psychiatric benefits create an additional treatment cost burden for the Medicare program for chronic physical illness. An analysis of 34 controlled studies on the cost offset effect of outpatient mental health treatment on medical care showed that there was more of the offset effect for individuals with advancing age. One study, in particular, examined the clinical outcome of a group of elderly patients who underwent orthopedic surgery for fractured femurs. Those receiving psychiatric care in the hospital stayed 12 days less than the patients who did not receive such services. The psychiatric treatment group was twice as likely to be discharged home instead of to a nursing home or other health-related institution. Psychiatric services provided clear cost savings by reducing health care utilization in other portions of the overall Medicare bill.

Catastrophic Health Insurance and Mental Illness

In 1983, the cost to society of all mental illness exclusive of alcoholism and drug abuse was estimated to be almost \$73 billion, about half of which could be attributed to direct treatment costs and the other half to indirect costs, such as loss of productivity or unemployment. The direct treatment costs represented about 9 percent of the total health dollar. It has also been estimated that 43 percent of these direct costs of mental illness are related to care and treatment of the severely mentally ill, the so-called catastrophic pool. Of all people with mental illness, less than 10 percent account for 43 percent of these costs.

Research funded by the National Center for Health Services Research has estimated that of the nearly 16 million American families, approximately one in five will incur catastrophic medical expenditures, and one-third of all of these families with catastrophic expenditures were headed by persons 65 and older. Catastrophic mental illness represents approximately 25 percent of these total catastrophic medical expenditures. Chronic and severe mental illness accounts for 25 percent of hospital bed days overall and over 40 percent of all long-term care beds. The costs associated with the care of the severely mentally ill can easily reach catastrophic expenditures, stripping the resources of American families and leaving them impoverished. Schizophrenia, for example, is a disorder that commonly begins in early adulthood or even late adolescence and cripples individuals throughout their most productive working years. Many of these individuals qualify for Medicare because they are on the Social Security disability rolls. They exhaust Medicare benefits at a very early point in the illness.

What happens to Americans when their mental illness reaches catastrophic proportions and their insurance coverage dries up? They may go untreated or they may be undertreated in community settings, they may face the ultimate disaster of becoming homeless, or they may be transferred to state mental hospitals for custodial care.

Rather than exclude mental illness treatment costs either from the catastrophic threshold or from the covered services, I would propose a system of utilization review and peer review, emphasizing criteria for continued active treatment, concurrent review of all treatments, and preadmission certification. Such "managed care" approaches are preferable to the arbitrary limits that most Americans now experience and to their dismay and shock find out only at the time a mental illness strikes a family member.

Most mental illness requires a diagnostic and treatment approach that does not differ from general medical conditions. As indicated earlier, reimbursement caps were recently lifted by the Department of Health and Human Services for the medical management of Alzheimer's Disease. This recognizes the need for a nondiscriminatory approach to mental illness coverage and should be recognized in a reform of the Medicare program. Representative Thomas J. Downey of New York introduced HRI067, the Medicare Mental Illness Nondiscrimination Act, on February 10, 1987. I commend this bill to the committee for serious study and consideration.

I would urge the federal government in its effort to protect Americans from the ravages of catastrophic medical illness to include those with catastrophic mental illness. Effective diagnosis and treatment is available, and the funding of treatment totally inadequate. Change in the Medicare program is long overdue.

Chairman STARK. Thank you very much. Mr. Gilbride?

STATEMENT OF DENNIS GILBRIDE, PH.D., DIRECTOR, MENTAL HEALTH COST CONTAINMENT SERVICES, INTRACORP, WAYNE, PA

Mr. GILBRIDE. Yes. My name is Dennis Gilbride, and I want to thank you, Mr. Chairman, for this opportunity to testify on what clearly is an issue of exceptional national importance. I represent Intracorp, a national disability management and cost-containment company. Intracorp is a subsidiary of CIGNA Corp., one of the nation's largest insurance and financial service organizations.

Intracorp has been providing case-management services to insurers and employers for 16 years, starting in 1970 with disability management services and growing to include medical case management of serious illnesses and, most recently, mental health claims. This outcome-oriented program seeks to not only control expenses, but to enhance the quality of care rendered.

As background, I have a doctorate in psychological counseling from the University of Southern California. At Intracorp I am director of mental health cost containment services with responsibility for assisting in the management of literally hundreds of very serious psychiatric disability cases.

As you are aware, the private sector has instituted a number of strategies to contain the escalating costs of medical and mental health care. These strategies apply equally to the needs of the elderly and the general population. These strategies have included alternative delivery systems, such as selective contracting through PPO's, and managed care offered by HMO's. Other cost-containment trends have evolved from limiting benefits to instituting utilization review programs and, most recently, case management. This first cost-containment trend is geared toward limiting mental health benefits and separating mental health and substance abuse insurance coverage from major medical coverage.

Insurance companies and employers have increasingly reduced the level of coverage applicable to mental health care and the number of inpatient days allowed. Where in the past coverage of mental health and substance abuse may have been approximately a million dollars a year, current trends range from \$10,000 to \$50,000 caps on reimbursement.

The rationale of this approach is obviously to limit the potential exposure to the insurer. Unfortunately, this level of coverage is often not sufficient to ensure the patient receives the care he or she may require. This stopgap measure has resulted in increased spending of medical dollars under the plan.

Research has shown that patients who require but do not receive appropriate mental health services utilize the health care delivery system up to 300 percent more than patients not in need of this type of care.

Utilization review and concurrent utilization and precertification is outlined in the written testimony, and I won't go into that.

The third and most recent development in the mental health cost-containment area is what we call case management. Case management is designed to identify that small percentage of all mental

health hospitalizations which constitute the high dollar claims. A red flag system is implemented at the utilization review, or claims processing location, designed to immediately identify those patients who are at highest risk for serious and continued utilization of mental health services. This is particularly vital for the elderly, whose mental health needs often go untreated.

The case manager conducts an on-site evaluation and assessment of the patient's needs, reviews the current treatment strategies, and assists the physician in developing both alternatives to costly inpatient care and a comprehensive long-term treatment plan which will promote the patient's recovery.

The case manager, after meeting with all involved parties, submits written recommendations to the insurer, identifying and outlining alternatives and or supplements to the current treatment. The insurer evaluates the information provided by the case manager. If he or she agrees with the report recommendations, an administrative exception to the provisions of the mental health benefit plan will be made. In approving these alternatives, the result is a cost-effective alternative to continued inpatient hospitalization.

Participation on the part of the patient is entirely voluntary and requires written consent before the process can begin—that's the patient's written consent. At any time during the management of the case, the patient can elect not to utilize the service, to not accept the more cost-effective recommendations.

There are several benefits to a managed care program such as the one I just described. The patient benefits, because he or she received the most appropriate and comprehensive care available, rather than treatment which is driven by the policy limitation. Throughout the process, support is provided to the patient and family, unnecessary treatment is identified and avoided, and the patient receives the highest quality and the appropriate mix of care available.

The insurer benefits because inappropriate expensive care is avoided and future medical and mental health exposure is reduced.

To date, Intracorp's case-management program is consistently showing a \$12 return for every dollar invested. Intracorp's 16 years of experience have indicated that when a case is appropriately managed, both mental health and medical costs are significantly reduced, complications are avoided, and the patient frequently returns to a productive life within society.

Thank you.

[The prepared statement follows:]

PRIVATE SECTOR APPROACHES TO MENTAL HEALTH COST CONTAINMENT

Dennis Gilbride, Ph.D.
 Director, Mental Health Cost Containment Services
 Intracorp

There is no group more keenly attuned to the rising costs of health care than the private sector. Employers in the U.S. are faced with the challenge of reducing the cost of providing health insurance coverage for their employees without compromising the quality of care or the breadth of coverage provided. It is for this reason that employers have turned to private providers of disability management and cost containment services in their efforts to create a total managed care concept.

The private sector has instituted a number of strategies to contain the rising costs of medical and mental health care. These strategies have included the use of HMO's, PPO's, IPA's, and hospital bill audits to name a few. In addition, there are currently several trends in place to manage the high cost of this care.

In the late 1950's there was a breakthrough in the treatment of many mental illness diagnoses with the advent of psychotropic drugs. It became more acceptable within society to be hospitalized and treated for a mental illness diagnosis. The U.S. also saw a rise in the number of mental health professionals entering the treatment field. With the increase in these professionals coupled with our advanced technology there soon was a escalation in the cost of treating mental illness.

In addition to our advanced technology in treating mental illness the private sector began to see an ever increasing number of employees seeking treatment for substance abuse disorders which included both prescribed and non-prescribed drugs and alcohol abuse disorders. The first trend seen in the public sector was geared to reduce expenditures and to limit policy dollar amounts. Most benefit policies did not specify limits for the treatment of mental health or for drug abuse. And, most policies did not separate mental/nervous conditions from major medical coverage. As the dollar amounts spent for these diagnoses continued to increase, the private sector was forced to review benefit policies and employers began to place limits on available benefit dollars for each insured.

Private providers of mental health care and substance abuse treatment began to receive patients into facilities and programs who had a specific dollar amount or number of days allowed for the treatment of mental/nervous conditions. The dollar amounts vary from \$10,000.00 to \$50,000.00 per insured for the life of the policy to \$10,000.00 to \$50,000.00 per insured per calendar year. Additionally, as guardians of benefit plans began to see increased spending for drug rehabilitation programs, many plans were revised to set specific dollar or day limits for treatment of these conditions. Commonly seen limitations include caps on the dollar amount as low as \$10,000.00 per insured per life time to as high as \$50,000.00 and day limits usually set at 30 days per calendar year and in some instances per life time.

The reaction of the treatment providers to these limitations was intensified. Frequently, a patient in need of substance abuse treatment will be admitted to a facility with an initial diagnosis reflecting a drug or alcohol abuse disorder. If a policy has a day cap of 30 days, the benefit analyst who is paying the claim will frequently see this diagnosis change to one of a mental/nervous diagnosis to facilitate payment of additional dollars for treatment under the mental/nervous portion of the benefit plan.

The rationale of this approach of placing limits on treatment is obviously to limit the financial exposure to the insurer. Unfortunately this level of coverage is often not sufficient to ensure the patient receives the care he or she may require. This stop-gap measure has resulted in increased spending of medical dollars under the plan. Research has shown that patients who require mental health services that are not received, utilize the health care delivery system 300% more than patients not in need of services. This utilization is

reflected in an increased need for treatment for such disorders as hypertension, esophageal varices, cirrhosis of the liver, cardiac disorders and gastrointestinal disorders. In addition to increased usage of medical care, these individuals will have decreased productivity in the workplace. This will be seen in the form of increased absenteeism, increased payment for short-term and long-term disability benefits and an increase in the number of work-related injuries which will result in the employer experiencing a rise in the company's worker's compensation benefits.

And, the increased expenditures will not stop with just the insured. Frequently an entire family will be covered under one benefit plan. When a member of a family is suffering from a mental/nervous condition of a substance abuse problem, all family members are affected. Frequently children will be hospitalized with adolescent adjustment disorders. Many times, the spouse of the patient will also have a substance abuse disorder and treatment will be required.

Unless the root of the problem is identified and appropriate treatment instituted, health care dollars will continue to be spent with no resolution in sight.

The second trend began in the early 1980's when employers and insurance companies began to adopt the policy of utilization review into their benefit plans. Utilization review is a service which measures the severity of illness of a given patient and the intensity of service which the patient is receiving. When incorporated into a benefit plan, it is the responsibility of the patient or physician to phone the utilization review firm and advise when a hospital admission is scheduled. When the admission is on an emergency basis, this phone call is usually required within 24 to 48 hours from admission. This notification will trigger the review process.

Depending on the type of service purchased by the claims payer, the review will be processed either by a registered nurse or a physician. The initial information gathered by the reviewer will include insurance policy number, patient name, address, birthdate, social security number, facility where the patient is hospitalized, primary physician, and diagnosis. The reviewer will then proceed to discuss the patient's condition with the treating physician.

The utilization review firm uses established criteria to certify admission. Included in this criteria is the normative length of stay for the procedure or diagnosis. The reviewer will certify the hospitalization for an established number of days and confer with the treating physician as to when it will be necessary to review the case for continued hospitalization. If all proceeds well, the case will be closed upon patient discharge. Should complications arise, the length of stay will be extended based on the severity of illness criteria.

When a patient experiences serious complications, health care expenditures increase exponentially. It is for this reason that employers have elected to begin managing their claims dollars through a case management program, the third trend to date. Employers who have instituted this cost containment measure are realizing approximately a \$12.00 return on every dollar spent for the management of both their medical and mental health care costs.

There are two primary methods employed by the private sector for identifying those individuals who will potentially be high users of mental health services. The primary and most effective method is to institute a pre-admission certification program. As described above, when a patient is admitted for in-patient mental health services either the patient or physician is responsible for notifying the utilization review company. Once the identifying information is phoned in, the reviewer will evaluate the case and the merits of medical case management services. Should the case meet pre-determined criteria, the reviewer will phone the claims payer describing the current situation and indicating possible alternatives which might be available. If approval for case management services is given, the referral will be phoned to a case management coordinator specifically qualified to manage cases within the mental health field. Prior to giving this approval, the claims payer will verify that the patient indeed is currently eligible for benefits and that monies under the

policy limitations have not been exhausted. Frequently, employers will offer the service regardless of existing policy limitations.

Upon referral to the case management network, the case management coordinator will phone the family of the patient and advise that the employer/insurance company has case management services available and that this service is being offered to assist the insured during their time of need. The service is entirely voluntary and the family/patient may decline the offer. Should this occur, the pre-admission process will continue and the case management process ceases. Should the family/patient elect to utilize the service, the case management coordinator will schedule a meeting with the family/patient to obtain a signed consent form and will begin the initial evaluation process. This process involves exploring the current family situation, discussing with the family/patient the past medical history of the patient and evaluating possible alternatives which may be available.

Meetings are then scheduled with the attending physician to assess the current treatment plan. Frequently it is at this stage that alternative plans are identified and approval of the attending physician is given. In many instances of mental health and substance abuse cases the attending physician is unable to recommend an alternative plan due to the policy restrictions.

Alternatives which are not usually covered include transitional living facilities, day care treatment centers for adolescents and halfway homes for recovering substance abusers. In addition, policies often limit either the number of visits or the dollar amounts available for outpatient psychological services.

Patients frequently remain hospitalized when indeed they could be transferred if these services are made available. If the patient and family are unable to finance these alternative services the treating physician has no recourse but to continue to hospitalize.

In addition to providing health insurance coverage as a benefit to employees, many employers have recognized the increasing importance of employee assistance programs and have adopted these programs within their organizational structure. These programs have proved to be invaluable in recognizing the high risk patient and assisting the patient to obtain the highest quality care in the most cost effective manner. When case management is utilized in conjunction with an EAP program, the case manager increases the patient's awareness of the internal services available through his employer. Upon discharge from the hospital or alternative treatment program, the EAP program will follow the employee and offer support and guidance for his/her continual involvement in the long term treatment plan which has been established for the employee.

The second primary method of identifying those individuals who will potentially be high users of mental health services is through the claims office. For those employers who administer their own claims internally, a training program has been established listing specific criteria for case identification and for case referral. For the employers whose claims are processed through a third party administrator, this same training is available if the third party payer chooses to utilize the service. Frequently, mental health providers will telephone the claims office to verify benefits are available for a given patient being admitted. It is at this point the initial notification of hospitalization is received. Based on the criteria the claims payer will make a determination to refer the case to case management services. If the case is referred, the process will begin as described above. Should a facility not call for verification of benefits, the first notification of the hospitalization will frequently not occur until the provider of the service forwards their invoice to the claims payer. This obviously is not the most efficient method of identifying potential high users of benefit dollars as frequently large sums of dollars have been spent before identification occurs.

In summary, there are several components needed to effectively manage potential high users of mental health treatment through a case management program. The primary component is that of early case identification. As stated, the most effective way to do this is through a pre-admission certification program. In the absence of this program, the claims payer must be knowledgeable regarding how to identify these cases. The second component which is critical is the expertise of the case manager. The case manager must have a thorough knowledge of the mental health system, must possess the knowledge of available community resources, and must be attuned to the potential complications that can occur with a given diagnosis. They must additionally be aware of how the patient's diagnosis may impact on the family who ultimately may be eligible for health care under the same benefit plan. A third primary element is the ability to service an employer who may employ workers in several locations throughout the United States. It is very difficult at best for a case management company to control case managers who are not employed by them and with whom they subcontract. It is critical that these complex cases be managed on site and locally. No attempt should be made by those unknowledgable in the mental health field to identify possible alternatives without having access to the family.

As employers continue to move toward a total managed care system it will be important to recognize the need for mental health coverage. It is becoming increasingly evident that medical benefits will continue to be utilized in an uncoordinated fashion when mental health benefits are not provided. Additionally, employers will continue to seek increased productivity and decreased worker's compensation claims which ultimately may be related to the employee's mental/nervous or substance abuse condition. If we are to continue to support freedom of choice of provider and employer subsidized medical benefits, it will be critical that we move in the direction of a total managed care concept which contains the element of case management for the purpose of evaluating quality and containing health expenditures.

Chairman STARK. Thank you very much. On a different topic but on the same panel, we are pleased to have Dr. Meskin. Doctor, would you proceed?

STATEMENT OF LARRY MESKIN, M.D., DEAN, SCHOOL OF DENTISTRY, UNIVERSITY OF COLORADO, BOULDER, CO

Dr. MESKIN. Thank you, Mr. Chairman. I'm Dr. Larry Meskin, dean of the University of Colorado School of Dentistry. As a dentist, I'm extremely pleased to be invited to testify on the dental health needs of the elderly and the relationship of these needs to catastrophic illness.

I would like to compliment you, Mr. Chairman, for your recognition of the importance of dentistry in this discussion.

America's children and young adults have become active participants in a society that is almost dentally disease-free. One-third of these youngsters, age 17 and under, have not demonstrated a single surface of decay. Our middle-aged adults have also shown remarkable gains in dental health. Only 4 percent of employed adults have lost all of their teeth. This outstanding display of excellent oral health is not yet shared by our elderly.

Unfortunately, recent studies show that more than 40 percent of individuals over 65 have no teeth. In addition, these people demonstrate significant decay on the roots of their teeth, with 63 percent of them so affected. Only half of these lesions have been treated. The majority of older adults show signs of periodontal disease that increase with age. Forty-seven percent of our seniors demonstrate bleeding gums and severe periodontal destruction was noted in 68 percent of these older individuals. The importance of these statistics is that a large reservoir of infection exists in this group, and in a healthy senior, the prevalence of these diseases may discomfort and infection and thus interfere with normal mastication and digestion. Breath odors and unsightly appearance may also carry heavy social consequences.

However, the same conditions can have life-threatening consequences if they exist untreated in patients who have suffered catastrophic diseases. For example, failure to clear infection in a patient with kidney failure on a dialysis regime can result in a bacteremia—that's bacteria in the bloodstream—which can cause serious infections throughout the body. Similarly, any patient undergoing heart surgery, indeed any major surgery, can be threatened by oral-initiated bacteremias. In addition, patients placed on immunosuppressant drugs who are undergoing radiation therapy, which depress bone marrow function, are at a high risk for serious systemic infection derived from these untreated foci of inflammation in the oral cavity. Indeed, scientific reports indicate that patients with heart valve replacements, or even those who have had hip replacements, have been affected by inflammation derived from these centers of infection in the oral cavity.

Therefore, it should be evident that comprehensive dental treatment for these compromised patients is essential to their well-being. Through appropriate legislation you can assure that there will be no financial barrier to their obtaining needed dental treatment. This should be the case both for those who require dental

care in conjunction with medical treatment, for those who need dental care but have difficulty paying for these services because they have already faced the financial losses that qualify them for catastrophic benefits. Most important, this treatment can be achieved at an extremely low cost. Estimates of the dental insurance industry indicate that comprehensive dental services for this group, those who would receive catastrophic benefits, could be realized for just 25 cents a month. I have attached a paper that would outline these cost estimates.

I'd also like to take this opportunity to stress my concern that basically there are no dental benefits provided under Medicare. The dental needs of this population group are extensive. More and more elderly individuals are retaining their teeth. This beneficial situation results in a need for more services in order to maintain these teeth. In addition, there are still 12 million persons who are over age 65 and are without teeth, and well over a million of these individuals don't even have dentures. These senior citizens also need regular dental care to prevent further deterioration of their oral health. Also, dentists are often the first health professionals to see manifestations of various illnesses, such as AIDS, diabetes, leukemia, oral cancer. Dental examination and proper referral could help assure less costly, more effective treatment of these conditions.

I urge coverage of basic dental services for the elderly under Medicare. The relative modest additional premium of approximately \$6.75 a month would provide the necessary and wanted benefit.

Again, I thank you for this opportunity to appear before you. I'm extremely pleased with your interest in the dental needs of the elderly. And at this time I'd be pleased to answer any questions.

[An attachment to the prepared statement follows:]

COST ESTIMATES

Dental Care Under a Medicare Catastrophic Program.

Assumptions:

90% (29 million) of eligible enrollees will choose the catastrophic benefit.

3% (870,000) of those who elect benefits will become eligible for them.

50% (437,500) of these will utilize covered dental services each year.

Benefits: 100% coverage for:

Prophylaxis, X-rays, Simple restorations, Full and partial dentures, Surgical preparation of ridges, Periodontics, Endodontics.

Average annual cost of dental care for each catastrophic program enrollee who becomes eligible for catastrophic benefits (870,000 people)—\$101.

Cost per catastrophic enrollee (29 million people)—\$3.04 per year, 25 cents per month.

Dental Care As Benefit for all Medicare Beneficiaries.

Assumptions:

70% (22.5 million) of eligible enrollees choose dental benefits.

50% of these will utilize covered dental services each year.

Benefits:

80% coverage, 20% copay for benefits outlined above.

Average Cost Per Enrollee for full Medicare Population—\$81 per year, \$6.75 per month.

Chairman STARK. Doctor, thank you. Let me just see if I understand your cost estimates here. It is not that I want to just cut down on your benefit before it even starts, but the 25-cents-a-month benefit looks a little better to me than the \$6.75-a-month, because I think I might be able to get it.

But I gather what you are suggesting, again, if I read this right, is because we would only touch about——

Dr. MESKIN. Three percent.

Chairman STARK. 900,000 people.

Dr. MESKIN. That is correct.

Chairman STARK. What you are saying is that they should spend down to the first \$1,500 under our bill or \$2,000 under the administration's bill, and then we click in and add dental costs above that.

Dr. MESKIN. That is correct, sir.

Chairman STARK. We could do that, you estimate, for about 25 cents a month to provide the minimum benefits that you feel are proper.

Dr. MESKIN. Actually it would provide maximum benefits for these individuals.

Chairman STARK. Total coverage for \$6.75 a month.

Dr. MESKIN. Yes.

Chairman STARK. Well, I appreciate that, and I know that it is a concern. I know anecdotally of many cases of seniors who have put off decent dental care, and I think sometimes have been seduced into full plates when perhaps more expensive types of procedures would have preserved some of their natural teeth for a longer period of time and probably been better for them. I am not a judge. I hope that this committee can find some way to begin to provide that care.

Let me turn, if I can, to the other topic. Let me ask one more question of you, and I guess I can only ask you this as your personal opinion.

But do you suppose that dentists or doctors of dentistry would be willing to support a fee schedule and a mandatory assignment provision as part of a medicare dental benefit?

Dr. MESKIN. I don't think at the present time I am equipped to answer that question without being schizophrenic. I don't think the profession has given enough consideration to the inclusion of dental benefits under Medicare.

I do feel, though, that as the number of seniors increase, and as you know, they are increasing in large amounts, that we are going to have to face this issue and perhaps that would be something we consider.

Chairman STARK. As a practical matter, and I am trying to think in the State of California, but there is a State dental plan that I gather is very widely used by all dentists in California. Doesn't that have a fee schedule, a before-fee schedule?

Dr. MESKIN. Yes.

Chairman STARK. Do you know what percentage of the dentists in California subscribe to it? I think it is high.

Dr. MESKIN. It is very high.

Chairman STARK. So that really would be kind of a participation and a fee schedule.

Dr. MESKIN. Sort of in a mix, yes.

Chairman STARK. Thank you very much.

One of the reasons that the Medicare mental health benefit has not been improved since 1965 is the lack of data showing how the elderly would be helped by the expanded outpatient health benefit.

We would be interested in knowing what evidence there is to support the benefits for the elderly. I presume they are done in a cost-effective manner. Dr. Sharfstein, can you shed some light on that? Do you know?

Dr. SHARFSTEIN. In my testimony, I allude to several studies, and I think there are a number of studies which do indicate the beneficial effects of psychiatric care, outpatient psychiatric care as well as psychiatric consultations in general hospitals.

The best controlled studies are ones that examine the impact on other costs—costs of medical care, the costs related to lost productivity in the employed population. And I think it is clear that psychiatric treatment seems to have an impact on these costs; and in the elderly population especially the high medical bills associated with mental illness with a combination of physical disability is one area where I think that you get into some immediate cost implications.

The other part, and I do emphasize this in my testimony, is that the outpatient benefit is so poor that, if an elderly person comes into my office and needs a diagnostic work-up, has a complicated problem, in order for me to financially protect this patient, I will recommend that he or she go into the hospital for a few days for this diagnostic work-up, much of which could probably be accomplished as an outpatient.

I am sure that that is very cost ineffective at this point for Medicare.

Chairman STARK. Okay. Let me follow on, if I may. You heard Mr. Gilbride talk about some of the work that they are doing in trying to contain costs. Could you, Dr. Sharfstein, accept some kind of gatekeeper approach and prior approval as part of this program, if we were to expand the mental health benefits?

Dr. SHARFSTEIN. Absolutely. In fact, it is our experience now in the private sector that many insured individuals come to, for example, Sheppard Pratt, and they are part of some kind of managed care system. It may be the Intercorp program; there are several others out there. We do now work very closely with a variety of systems and different kinds of case managers in both approving initial hospitalization as well as concurrent utilization review.

I think that we do quite a bit of utilization review within the hospital itself, and so we are very familiar with the standards that are needed to be maintained in order to have continued care.

You do get to a point with some of these reviewers of diminishing returns. For example, they expect a complete report every two days or every three days of hospital care, and it can be some perhaps excessive zeal in some of the programs. Our experience with the Intercorp, that has not been the case, but with several other programs we have had, let us say, headaches.

Sometimes you get into a situation where the case manager strongly recommends discharge, and the patient is acutely suicidal and in need of ongoing care. At that point I think it is important that you have some mechanism, and most of these managed care programs have a mechanism of appeal and in some instances actually a site visit on the part of the case manager to the hospital to ascertain firsthand, from the medical record as well as from the patient, that the care is medically necessary.

Of course, you have to get the family's approval for this, and that is very important as well.

Chairman STARK. Let me move one step further. This is the sort of anecdotal things that form a lot of prejudices that at least, I, as a legislator run into. But I recall years ago an article in one of the local papers suggesting that we had the highest ratio of psychiatrists to population in the District; largely in the article's theory it was because of the very generous mental health benefits that most federal employees enjoy. This was an attractive place for psychiatrists to practice.

I also was aware of some young people that I knew, actually former employees of mine, who were able to go into complete psychoanalysis, which I gather is a pretty expensive proposition. Obviously, I am not skilled at determining whether somebody needs help or not, but this particular employee basically indicated that they went through this analysis because it was there and they could collect the money anyway. That was the impression I got.

And I suspect that that is a concern which is prevalent in the whole idea of cost containment. I do not think that I worry so much about people having a whole gum flap operation because it hurts like hell and I think they would avoid it, as I would, at any cost. But the idea there might be a sort of curiosity factor in going through analysis, and if you liked your psychiatrist a lot, it might be fun.

I mean that seriously. I do not think there is anything wrong with that, but, Doctor, how do you address our concerns in the absence of some real tough either peer review or gatekeeping at the cost containment area, where we are so inept as laymen in determining?

If somebody has a broken arm, you know whether or not it gets fixed. There are certain illnesses, it seems to me, from which you recover. It is such a definitional problem in your field of expertise.

Can you make me feel better about our paying a lot of money in that? And then I know that your colleague on the panel wants to make me feel better in a minute. Let me get your answer first.

Dr. SHARFSTEIN. Well, I think what you have just described is the Woody Allen stereotype of psychiatric care; that is, somehow psychiatric care is never-ending and it is more recreation than it really is therapy.

I do not think that is true. I think that if it is true, it is something peer review and medical necessity review can easily pick up.

In fact, Washington, D.C., and this is something I have actually studied, is second in the country in terms of the density of psychiatrists. Downtown Manhattan is actually number one. Though Washington has a high density of psychiatrists, the good coverages, the psychiatric coverages, were actually cut back 5 years ago pretty dramatically in the Federal plans.

Interestingly, this was a kind of empirical study, I think, of supply and demand and manpower. I wondered how many psychiatrists would have to move out of Washington because of the cuts in the Federal plans. I made a flat out prediction—I have a little bit of an economics background—that a hundred psychiatrists would have to move out of Washington in the first year, and I began to

think about what other areas of the country which are underserved in terms of psychiatry that might benefit from that.

In the first year, there was a net gain of ten into Washington. The number of psychiatrists in Washington have remained very high, and it is because people will pay for needed psychiatric care out-of-pocket and there is a lot of psychiatric care provided through the public sector.

Most people who come to a psychiatrist, and there are studies that I can show you on this, have severe and serious medical conditions. They need competent diagnosis; they need treatment; they need hospital care; many need medications; they need good diagnostic work-up to rule out physical illness. And I think it is very important that that be provided for under the Medicare program. The patient that I described to you has a medical condition for which there are effective medical treatments.

Mr. LEVIN. Would the Chairman yield?

Chairman STARK. Certainly.

Mr. LEVIN. I think that your question strikes at the heart of the matter for a number of members. I do not know the history of the severe limitations on reimbursement.

There may have been some prejudices, one might call them that, in the determination, and maybe a lot of ignorance. I take it, though, there also was a lot of question as to where you draw the line.

In simple layperson's language, what is really needed and what is not?

In answer to the chairman's question, Dr. Sharfstein, you talked about peer review, and other management techniques. With Alzheimer's there has been a somewhat different approach, as I understand it.

Maybe you could elaborate on that a little further. If we are going to take a serious look at this—and at this point I am not sure that is going to happen—there is going to have to be a serious, realistic, feasible, not too complicated—

Chairman STARK. That is for my benefit.

Mr. LEVIN. No, no, in implementation. I mean, it not only has to be understandable but easily or relatively easily implemented.

So tell us, how do we design a system? In a few minutes, give us some more ideas.

Dr. SHARFSTEIN. Well, now, we are talking about outpatient care, and then I might say something about inpatient care.

In terms of outpatient care, I think it would be good to re-examine the \$250 limit for psychotherapy, which includes psychoanalysis which is one form of psychotherapy, and perhaps you need to have some dollar limits on that. I would think that going from \$250 to \$1,000 to keep up with inflation, you would have to go to \$2,200 for that particular benefit.

But then when it comes to the medical management of psychiatric conditions other than psychotherapy, I would treat it in the same basis as you treat the medical management for all conditions. Now, what do I mean by "medical management?"

Well, my patient with bipolar psychiatric depressive illness—that means she has both highs and lows—needs to see me once a week for 20 minutes. I take her blood pressure. I check on the side ef-

fects of her medication. Once a month I will take a blood test to check on her lithium level. I will bring in the family on a once-a-month basis to help counsel them and their dealing with her. If she develops various kinds of symptoms, I can order diagnostic tests ranging from electrocardiograms to blood samples for her electrolytes, et cetera, that are very important in relation to managing a patient on this medication.

The patient has to continue to take the medication in order to avoid a relapse. So, therefore, weekly visits are important. Very rapidly, you are going to reach the \$250 threshold or any other threshold, and it would seem to me it would be very important to exempt that kind of care, which is not that different from the care of a diabetic with severe diabetes and in need of insulin monitoring.

When it comes to inpatient care, I think you can augment the professional review organization system of Medicare through a concurrent review system to review the necessity for more extended inpatient psychiatric care. We have now in the private sector a great deal of experience in that kind of managed care for patients who need more than acute hospitalization.

Most people with mental illness can be treated in an acute time frame. There are a small number—probably ten percent, and no more—who require ongoing inpatient care because of the severity of their condition.

At this point in time, when they reach the limit of their Medicare benefits, they need to be transferred to a state facility, and I think a number of these people, particularly the non-elderly Medicare beneficiaries, end up on the street. If you interviewed the number of homeless in this country who have schizophrenia and find out whether they receive Social Security disability and what has happened to their Medicare benefits, I think rapidly you would find a very good cogent cause for the epidemic that we have in the nation's capital and in many other cities in the country.

Mr. LEVIN. Do you think we need any further demonstration efforts, or are you confident we can devise an expanded but controlled, pinpointed system in this area? I ask because I think there is a lot of shyness. I am not sure how many I speak for, but I think there is that.

Dr. SHARFSTEIN. I think we have demonstrated and demonstrated. There have been a number of demonstrations on this issue, one focused on community mental health centers recently completed. I think it can be shown that there is a way, a cost-contained way of expanding the benefits and making the overall program more effective for Medicare beneficiaries.

Mr. LEVIN. Thank you, Mr. Chairman.

Chairman STARK. Dr. Sharfstein, one other question—actually two. Would you have any objection to a fee schedule and mandatory assignment, and the third part, would you have any objection to recognizing psychologists as providers under part B?

Dr. SHARFSTEIN. Well, now, we are getting into some real controversies.

Chairman STARK. We do that here every day. You are here to help us out of them.

Dr. SHARFSTEIN. Right. In terms of fee schedules and mandatory assignment, as long as this was applied across the board to physicians—internists, surgeons—I think that that would be something that we could live with. I think there is a problem with some of that. In Massachusetts, for example, as part of the minimum mandate insurance benefit, they regulated psychiatrist's fees so low that it just became impossible for physicians to treat patients in that particular system. But I do think this is something that should not just be applied for psychiatric care.

In terms of psychologists as part B providers, it is my opinion that this benefit should be medically managed. What I mean by that is that the initial diagnosis and treatment ought to be provided by a physician. Elderly patients, especially, have a combination of psychological and physical problems, and there ought to be some, if you will, gatekeeping in relation to that particular complicated combination.

Chairman STARK. How do I deal with the psychologists' complaint that they do not get any of them?

Dr. SHARFSTEIN. Let me finish.

I do think psychologists are important providers of both diagnostic and treatment services for the mentally ill, and they should have access to Medicare benefits after the initial medical assessment is accomplished. For example, psychologists are competent to perform psychotherapy, and psychotherapy is a valued and valuable benefit for Medicare beneficiaries. I think that there are a number of diagnostic tests that are very important as well.

I do think that from the point of view of both cost containment and the medical nature of the Medicare program that the initial triage should be performed by a physician.

Chairman STARK. Okay. How do I answer the psychologists who say that the M.D. psychiatrist will not let them share any of the work? In other words, my understanding, and this is probably oversimplified, is that the psychiatrist can do everything the psychologist can do, but the reverse is not true. So that if the psychiatrists were short of work and also the gatekeeper, the psychiatrist could keep the patient, and ethically, even though there was not any of the medication or whatever the special talents that the M.D. provided that the Ph.D. did not.

How do you answer that? Is there a system we could devise? And I gather that this has some implication on other than just Medicare patients because of various hospital rules.

Dr. SHARFSTEIN. Let me say two things about that, and then I would ask Ms. Robbins to help me out with that.

Chairman STARK. Okay.

Dr. SHARFSTEIN. I hate to put it exactly this way, but I think that there are more than enough patients to go around. I mean, in terms of the prevalence—

Chairman STARK. You can put it that way.

Dr. SHARFSTEIN. Okay. The prevalence of mental illness in this country, it is not possible for psychiatrists to keep every patient. I do not think that is possible.

I think it is possible for psychiatrists to triage every patient, but I do not think it is possible for them to keep every patient.

Chairman STARK. There are only so many hours in the day.

Dr. SHARFSTEIN. There are only so many hours in the day and all the rest.

The second part of that is—I forgot the second part. I will let Hilda—

Mr. GILBRIDE. Can I respond to that, too, Mr. Chairman?

Chairman STARK. Sure. I am saving the best for last, Ms. Robbins. I am going to let you summarize, so I am not avoiding you here.

Ms. ROBBINS. Well, I would like to respond to this. I think that Congressman Levin expressed the idea when he said he was not familiar with why some of these discriminations were written in to the original bill. I think that is understandable.

As I said in my testimony, the treatment and the kinds of outpatient care for patients has changed tremendously in the 20 years since Medicare was instituted. And in response to the idea that a psychiatrist might try to keep all of the patients, I think that 20 years ago much of the care that was given to any patient was given on an individual basis. That was before the time of community mental health centers.

Now, most situations are organized mental health systems that use a team approach, and most patients respond to the team approach. I think that that was not in existence at the time Medicare was originally introduced. It is that team approach that keeps the balance of services in order.

I would also suggest that you do not find very many people over 65 going for psychoanalysis because that is something that usually, if it is needed at all, it is needed when someone is in early life or mid-life.

I would also suggest that there has always been the implication that psychiatric patients might go back for more services than they really need. I have been receiving psychiatric care since I was a teenager approximately every 3 or 4 years, sometimes for 3 or 4 months and sometimes as long as 2 years in a stretch. And you do not go back because it is fun. It is painful and it is a very disagreeable and completely devastating time in your life when you become mentally ill. That is why I feel so strongly that there is not a recognition of what the true need of people who are mentally is.

There is no person in our society that is more vulnerable than a person who has been diagnosed as schizophrenic. These people usually become ill in their late teens or early 20's, and that is a catastrophic situation for the rest of their lives in many, many instances.

Chairman STARK. Is there a cure? Is there a known cure for schizophrenia?

Ms. ROBBINS. There is no known cure. Some people say that approximately one-third of people who have been diagnosed as schizophrenic can hold a job and perhaps have relapses. Others will perhaps need some fairly structured supervision. But approximately one-third of that 1 to 1½ percent of the population are going to be needing tremendous amounts of supportive care of the kind that have been described—case management, and rehabilitation services. And they do respond to that. There are a lot of psychosocial rehabilitation services available now for people who have in past years been considered untreatable or unable to be helped. Now

they can be helped so that they can hold a part-time job, perhaps have a relapse, and then go back to the job. It is possible with the right services that are available.

Chairman STARK. Mr. Gilbride, you had a comment.

Mr. GILBRIDE. Yes. One way of dealing with this psychiatrist—

Ms. ROBBINS. I think also that there was a time when, and I guess it was Congressman Levin who said that you cannot identify this specifically, but now that we are finding out more and more about the genetic emphasis of psychological and psychiatric illnesses, I think that you can pinpoint those things.

There was research that was reported less than a month ago that indicated that on the short arm of chromosome No. 11 you can find a defect that would indicate an extreme vulnerability for manic depression. With that kind of specific biological kind of evidence, there is no reason that it should be so suspect to suspicion as it has been in the past.

Chairman STARK. As a matter of fact, I am inclined to agree. In the sense of the way we talk about the abuse of fees, abusive fees being charged to the system, assuming that both psychologists and psychiatrists stay in the same range that they get by the hour, I would imagine that they are right down there with pediatricians among the low-paid group.

I do not know. Maybe you could speed up and only cut your consultation time from 50 minutes to 30 minutes and in the process sneak one more patient a day. But even that does not seem to me, just in terms of aggregate dollars to the system, the same as \$6,000 heart transplants, which might be done more rapidly.

So I am not suggesting that there are people drumming a lot of work here. There is some question between psychiatric and general hospitals, for example. Hopefully, under our catastrophic bill, for those hospitals that are general hospitals that have psychiatric units, the inpatient costs will be helped significantly.

Now, that does not help the special psychiatric hospital that is paid under a retrospective fee. I would hope that we could solve that, perhaps, by getting to some form of prospective payment, but that probably is more difficult to establish.

I would just say to the panel, including the area of dentistry, that there is tremendous pressure from other than the providers to broaden a whole host of medical, dental and mental health benefits. And as one of the earlier witnesses indicated, it is not the ways; it is the means. We are in the uncomfortable position because probably every member of this Subcommittee would like to provide every benefit that every senior citizen and every junior citizen needed.

We have got to ration and triage has not, at least among politicians, become a very acceptable alternative. It is one that is more familiar to the medical community but not the political community. We appreciate very much your help here because sooner or later that will be our decision—and it will not be easy—as to how can we with very limited resources allocate them? Your testimony is appreciated.

Ms. ROBBINS. I can appreciate the limited resources very much. Earlier today with the first witness here, you talked about if we had a windfall of \$2 billion and so forth. I would hope, Congress-

man Stark, that we do not have to wait for a windfall for some of the discrimination and injustices that are in Medicare today to be corrected, because they are there because of a lack of information. Now there are new kinds of treatment, new kinds of information and diagnoses. I think that it is important that this legal discrimination be lifted from this large population.

Chairman STARK. If we could do it without having it cost anything, Ms. Robbins, there would be no problem. But the problem is when you are hooked under this crazy Gramm-Rudman nonsense, for every dollar I spend in one place I have got to take it away. Do I want to close a charitable hospital in an inner city that is providing barely adequate prenatal care to help somebody else here?

Those are the questions we are going to be faced—we did not get into it today—but the testimony on pharmaceuticals. We will be faced with AIDS which is going to, at least in my opinion, put the kinds of pressures on Dr. Sharfstein and his colleagues that they have not even seen yet if the predictions of what is happening are true. The fact is that we are not going to be able to cure it or slow it down. They tell me even this morning on the Today Show that the sales of condoms are not going up, and I want to tell you that that can only lead to just a huge cost.

The cases are \$145,000 apiece. There are approximately 80,000 cases in California where they have been a little more willing to take the AIDS patient into the mainstream medical provider system. We are in deep trouble. And Blue Cross today said they are not going to provide the drug, AZT or whatever it is, under their insurance.

We have got a lot of big problems of people fighting over limited resources. I mean it. That is the biggest problem in this job, trying to figure out how to—scrap for our share of the budget pie. That is a fight you have to help us with the White House.

You can do away with Star Wars, as far as I am concerned. That would pay for a lot of this, but I do not have enough votes. So that is the problem. Just your willingness to point out to us both anecdotally and in an aggregate of costs of the needs and any information that you could provide us on how we save money.

There is some saving in prophylactic treatment and in preventive treatment. As we found out so magnificently in the dental field, there just are a whole lot less kids with cavities. It works. It really does, but sometimes we cannot pay for it.

Thank you. As usual, we have saved the best for last. I appreciate your willingness to be with us today.

The committee stands adjourned.

[Whereupon, at 1:22 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

WRITTEN STATEMENT FROM THE COMMITTEE ON HEALTH
OF THE AMERICAN ACADEMY OF ACTUARIES
submitted to the
SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
April 17, 1987

SUBJECT: Hearing on Expanding Medicare to Include Catastrophic Coverage (Held on March 30, 1987). The following statement is submitted for the printed record of the Hearing.

I. BACKGROUND ON THE AMERICAN ACADEMY OF ACTUARIES

The American Academy of Actuaries is a professional association of over 8,000 actuaries involved in all areas of specialization within the actuarial profession. Included within the Academy's membership are approximately 85% of the enrolled actuaries certified under the Employee Retirement Income Security Act of 1974 (ERISA), as well as comparable percentages of actuaries specializing in actuarial services for other individual and employee coverages such as life, health and disability programs. As a national organization of actuaries, the Academy is unique in that its members have expertise in all areas of actuarial specialization. Dealing with issues associated with health care financing and insurance is in part the responsibility of the Academy's Committee on Health.

The Academy does not advocate public policy positions which are not actuarial in nature. The Academy views its role in the government relations area as providing information and actuarial analysis to public policy decision-makers, so that policy decisions can be made with informed judgment. It is our belief that the training and experience of Academy members provide for a unique understanding of current practices in insured health care. Our intention is to communicate that understanding in ways that can be of maximum assistance.

It is with this objective that we submit the following comments for your consideration. These comments are confined to a summarization of facts (or estimates) concerning existing private catastrophic insurance supplemental to Medicare.

II. EXTENT OF EXISTING PRIVATE CATASTROPHIC INSURANCE SUPPLEMENTAL TO MEDICARE: How Widely Those Who Need Coverage are being Reached.

At least 70% of Americans presently covered by Medicare also have private insurance supplemental to Medicare. Nearly all of this private supplemental insurance includes coverage of a catastrophic nature, supplementing both Parts A and B of Medicare. A substantial fraction of this is provided through group policies (such as the coverage offered under programs of AARP, the American Association for Retired Persons, and similar programs) but the majority is probably provided under individual Medicare Supplement policies.

Virtually all of these Americans pay their own premiums for this insurance. Among the remainder who are not insured under either individual or group private Medicare Supplement policies, some choose not to pay for supplemental coverage, evidently regarding Medicare as sufficient. The remainder who cannot afford to pay for such coverage must rely on Medicaid for assistance.

III. EXISTING STATE AND FEDERAL MINIMUM BENEFIT STANDARDS FOR SUCH SUPPLEMENTARY INSURANCE: How Well the Need is Being Met for Those Covered.

Nearly all of the states (about 46 out of 50) today have regulations in effect which establish minimum benefit standards required to be met by all Medicare Supplement programs marketed in the state. These are generally similar to or identical with the existing Federal minimum standards (the "Baucus Amendment") enacted by Congress: where such state minimum standards differ from the Federal, they are usually more stringent.

1. Insurance Supplementary to Medicare Part A (Hospitalization).

With regard to Medicare Part A, the state and Federal minimum benefit standards generally in effect require that private policies must cover:

- a. 100% of that portion of Medicare approved hospital costs occurring after 60 days of confinement during any one spell of illness, but not paid by Medicare, up through 90 days and on through Medicare's 60 additional lifetime reserve days.
- b. 90% of the necessary cost of additional hospital confinement after Medicare stops paying, up to 365 additional days.

This is coverage of catastrophic scope and it is minimum coverage. Less than one hundredth of 1% of Americans covered by Medicare Supplement insurance would still be hospitalized upon expiration of this 365 days of extended insurance after Medicare's hospital payments stopped.

2. Insurance Supplementary to Medicare Part B (Medical care).

With regard to Medicare Part B, the state and Federal minimum standards generally require that private policies must cover:

All Part B Medicare approved expenses not paid by Medicare, in excess of a \$200 yearly "out of pocket" deductible and up to a maximum yearly benefit of \$5,000.

The part not paid by Medicare is the first \$75 of approved expense each year, plus 20% of the excess over the \$75. This means that, with respect to Medicare approved medical expenses, any one insured individual would have to have incurred a total of \$24,925 in Medicare Part B approved expenses in a single year, before reaching the point where his Part B Supplemental insurance ran out. The next year, however, his Supplemental coverage would begin all over again.

This again is coverage of catastrophic scope and it is minimum coverage, under Federal and most state minimum benefit standards.

Accordingly, representations that catastrophic coverage does not now exist or is unavailable to most senior Americans are not true. Such coverage exists and is widely available.

There is, however, another area of medical expense which would NOT be covered under these minimum requirements. This has to do with medical charges in excess of the amounts Medicare approves. It is estimated that, on the average, actual medical care charges exceed Medicare approved amounts by 25 to 40%, varying by locality and individual case. Many doctors accept Medicare approved charges as their entire charge, but many of course also do not.

However, as I will describe next, many existing private Medicare Supplement programs provide coverage that exceeds the existing Part A and Part B minimum standards, including some coverage for medical charges exceeding the amounts Medicare will approve. None of the legislation now proposed in the Congress is directed toward coverage of these excess costs, whereas many existing private plans provide such coverage.

3. Private Supplementary Insurance Exceeding the State and Federal Minimum Benefit Standards.

Many private Medicare Supplement programs being sold today exceed the minimum benefit standards described in the preceding 2 sections. This fact is the result of competition among the various private programs offered in the voluntary Medicare Supplement market.

- a. First, the Part A minimum standards are frequently exceeded. The majority of private plans cover the initial Part A Medicare deductible (\$520 per spell of illness in 1987). Many build this coverage right into the plan; others offer this as an added coverage option. In several states, it is required that this Part A coverage be offered as an option.
- b. Second, a substantial minority of private plans provide hospital insurance after Medicare stops paying at 100% of charges rather than the minimum of 90% actually required.
- c. Third, a number of plans provide this extended Part A coverage, after Medicare stops paying, without any limit as to the number of days, rather

than limiting the days of extended coverage to 365, as provided under the minimum standards.

- d. Fourth, under Part B Supplemental Coverage, the majority of plans cover Medicare approved expenses after only the \$75 yearly Medicare deductible or sometimes even from the first dollar, rather than only after the \$200 "out of pocket" deductible as provided under the minimum standards.
- e. Fifth, many plans provide coverage for medical expenses in excess of Medicare approved Part B expenses. This is done in various ways. Some plans will cover actual charges up to 120, 140, 160%, or similar percentages, of Medicare approved charges. Others will cover charges "not exceeding usual and customary charges", or the like, in the locality.
- f. Sixth, many plans, possibly even a majority of those being sold, do not contain any maximum yearly limit on Part B supplementary benefits, rather than \$5,000 as provided for in the minimum standards.
- g. Lastly, many plans provide supplemental benefits for long term nursing facility care: coverage not required under most Medicare Supplement minimum standards. This coverage ranges from covering what Medicare does not pay during the first 100 days, up to long term extensions of coverage well beyond 100 days.

Thus, many senior Americans are covered by catastrophic supplemental insurance far exceeding what the minimum standards require, and even the minimum standards require coverage of catastrophic scope.

IV. STATE AND FEDERAL MINIMUM LOSS RATIO STANDARDS (Ratio of Benefit Value to Premiums): Appropriateness of Standards in relation to Marketing and Administrative Costs.

1. Summary of Standards Prescribed.

In general, the minimum standards now in effect require that the premiums charged by private insurers provide for an expected 60% loss ratio for individual policies, and in a number of states 75% for group policies. Several states (for example, New York, Michigan and Minnesota) require a 65% minimum loss ratio for individual policies.

What these "loss ratios" mean, in simplified terms, is that, over the entire period the coverage continues in effect for the population covered, insurers must expect to return, as benefits, at least the stated percentage of the premium received, with both benefits and premiums calculated on an actuarially equivalent "present value" basis. Thus, a "60% loss ratio" means returning 60 cents of the premium dollar in benefits, over the entire period of coverage.

2. The Appropriateness of these Standards: the Level of Marketing and Administrative Costs Necessary Under Voluntary Private Insurance.

A common criticism made against voluntary or private insurance is that it simply does not return a sufficiently high percentage of the premiums paid or of the gross funds appropriated. It is sometimes argued, for example, that Medicare returns 97 cents or more on the dollar, while much of the private coverage is expected to return only 60 cents.

Substantial additional types of cost, which do not occur under Medicare, have to be recognized and provided for under any voluntary plan that is offered to the public. Among these costs are premium taxes, the cost of meeting state filing requirements, and the cost of billing and collecting the premiums. An even greater cost is the advertising and marketing cost. A voluntary private program that incurs no marketing costs is not going to be known to the public and is not going to be bought, especially when it is offered to individuals. It is not possible to have a successful voluntary, individually sold insurance plan and still realize benefit return ratios as high as 97% or even 80%. Even most of the "group" Medicare Supplement programs are actually sold and bought individually, and therefore have substantial "non-benefit" costs that must be provided for in the premium.

I will make no attempt here to quantify what a "reasonable" percentage of the premium allocated for provision of all these necessary costs should be. But I do have to point out that successful voluntary insurance programs of necessity must incur significant marketing and advertising expense, in addition to substantial administrative cost. Any fair criticism of the "benefit return" on the dollar must take these several facts into account. Most of the criticism directed toward the benefit return under private Medicare Supplement insurance ignores these substantial additional costs that must necessarily be incurred under private programs.

Respectfully submitted,

American Academy of Actuaries Committee on Health, by

E. Paul Barnhart, Chairperson

Testimony of

Edwin M. Cohn, M.D., FACG
National Affairs Chairman
of the
American College of Gastroenterology

Mr. Chairman and Members of the Subcommittee, on behalf of the American College of Gastroenterology, I wish to thank you for holding this important hearing. The time for us, as a nation, to address the problem of inadequate health care coverage is long overdue.

Today, approximately 30 million elderly Americans are exposed to financial hardship due to a catastrophic illness or long-term care need. Gastroenterologists see these patients on a daily basis. These individuals, most of whom have worked hard all their lives, should not be asked to surrender their life's savings because they have a serious or severe illness. The American College of Gastroenterology believes that something can and must be done to prevent the financial devastation that American families are enduring solely because one family member has a catastrophic illness or need for long-term care services.

ACG also believes that HHS Secretary Bowen's proposal is a step in the right direction. In addition to providing a mechanism for catastrophic illness coverage under Medicare, the Secretary's proposal is important for two reasons. One, it recognizes that the problem exists and should be remedied. Second, it perceives the Federal Government as having an important and necessary role in the process while remaining budget neutral.

However, the Secretary's plan does not go far enough and could be improved. It does not cover long-term care needs, nor does it cover the cost of drugs, as well as other costs; for instance, such as those for vision and hearing problems. Clearly, the Administration's proposal will need to be supplemented in order to best meet the needs of the American people. Nevertheless, Secretary Bowen should be congratulated for his valiant efforts to address this problem.

Mr. Chairman, much is being said these days about health insurance coverage for catastrophic illness, and as you know, numerous Committee and Subcommittee hearings are being held on this issue. ACG perceives this current debate as positive in that it has drawn attention to the severe consequences of the problem. Our major concern is that without passage of Congressional legislation, these discussions will remain mere rhetoric. The American College of Gastroenterology recommends that Congress move swiftly and thoughtfully to enact Federal legislation to provide Medicare coverage for catastrophic illness and long-term care.

Thank you for the opportunity to present our views. The American College of Gastroenterology is happy to assist you in any way Members deem appropriate.

TESTIMONY OF
Leonard D. Goodstein, Ph.D.
Executive Officer
AMERICAN PSYCHOLOGICAL ASSOCIATION

On behalf of the 87,000 members of the American Psychological Association, nearly half of whom are direct service providers of mental health services, we are pleased to present this statement on proposals for the coverage of catastrophic costs under the Medicare program.

The proposals introduced by the Honorable Fortney (Pete) Stark and Willis Gradison, H.R. 1280 and H.R. 1281, reflect sensitivity and understanding of the need for such protection for Medicare's elderly and disabled beneficiaries, and incorporate a responsible financing mechanism that protects the federal government's fiscal position. H.R. 1280 and 1281 represent a significant step toward addressing the truly catastrophic health care costs incurred by many of our elderly and disabled citizens, while supporting the mission of the Medicare program to assure that basic health care needs of the elderly are met and that coverage for acute disease and illness is available.

Since the enactment of the program in 1965, Medicare has undergone minimal reform despite major improvements in our understanding of the health care needs of the elderly and our ability to provide services. We now have over two decades of experience in witnessing, often with painful acuity, the shortcomings in the program. Nevertheless, the only major structural reform that has occurred has been directed at the financial incentives for unnecessary hospital care.

The fundamental flaw in all existing proposals to offer protection from catastrophic costs is that they are based on the existing Medicare benefit structure. They do not attempt to address the limitations of the structure itself. Instead, the focus is on protection from the burden of excessive costs incurred by an accumulation of currently allowable deductibles and copayments. Although this is a laudable improvement, it does not remedy existing gaps in coverage that often lead to catastrophic debts, nor remedy existing constraints on cost-effective alternatives provided by nonphysician professionals such as psychologists.

INADEQUACIES IN THE CURRENT MEDICARE BENEFIT STRUCTURE

Our special concern is for the serious gap in coverage resulting from the current mental health benefit. The benefit has not been improved in any way since the inception of the Medicare program in 1965, and remains at a \$500.00 annual limit with a 50/50 copay for allowable physicians' outpatient services and a maximum lifetime 190-day limit for care in a psychiatric hospital. All mental health services must be provided by, or under the referral and supervision of, a physician whose training need not include any specialized care for those with mental disorders. This benefit made little sense when it was adopted, but even less in 1987. It bears no relationship to the service needs of the elderly or disabled, nor to the clinical or service provision realities that prevail in other federal health programs or the private health care market.

The consequences of this limited benefit for the health care of the elderly and disabled in Medicare are profound. The inter-relationship between physical and mental health in the elderly is well documented; those with severe mental disabilities often have physical problems as well, and physical illness is often compounded by a mental disorder. By providing relatively generous benefits for physical health care services and restricted coverage for mental health services, Medicare encourages inattention to significant mental health problems and may promote inappropriate and harmful treatment. This is exacerbated by the insistence on physician provision and control over service delivery in two ways. First, there is no assurance that a proper diagnosis is made to identify both the physical and mental aspects of a given condition. Primary care physicians are not likely to refer the elderly for specialized mental health services. In fact, medication is the primary form of treatment by all physicians for symptoms or complaints of mental problems in the elderly; 95% of the psychotropic medications prescribed for the elderly are authorized by primary care physicians. Second, by restricting primary service provision roles to physicians, qualified non-physicians such as psychologists, whose entire graduate program of training is focused on the diagnosis and treatment of mental disorders, are constrained from responding to the service needs of the elderly and disabled Medicare population.

In effect the Medicare mental health benefit serves two populations: 1) the elderly, and 2) individuals under the age of 65 who are disabled because of a serious mental disorder. Psychologists' services can be of significant benefit to both these groups.

MENTAL HEALTH NEEDS OF THE ELDERLY AND DISABLED

What are the specific major mental health problems of the elderly? Mental disorders identified in most analyses include the following: 1) dysphoria and major depressive disorder; 2) high suicide rates, with men over 75 having the highest rate for all age groups; 3) alcohol abuse, polydrug use, and misuse of prescription drugs; and 4) dementia and cognitive impairment. Moreover, it should be noted that more individuals with chronic mental disability are now living into old age.

In addition to treating these major disorders, psychologists and other mental health professionals may also provide services to the aged to alleviate circumstances that may contribute to the development of serious disorders, such as stressful living situations, acute and chronic health conditions, and the burden of serving as a caregiver to a severely impaired family member.

THE ROLE OF PSYCHOLOGISTS

The mental health problems of the Medicare population require the expertise of appropriately trained professionals. Psychologists are trained to understand the predisposing causes underlying mental health problems whether these be behavioral, psychological, social, or biological in origin. The unique training of psychologists allows them to provide mental health services to the elderly and disabled by means of psychological assessment, psychotherapy, biofeedback, education, and consultation. More specifically, with regard to treatment, psychologists contribute to the optimizing of personal autonomy and integrity by teaching coping skills, providing counseling around predictable life crises, and by identifying socio-economic system factors that exacerbate mental disorders. In particular, psychologists' services to the severely disabled Medicare population behavioral interventions to curtail: dangerous, threatening or aggressive acts; verbalized delusions or hallucinations; inappropriate expressions of affect; incoherent speech; extreme bizarre behaviors; and unusual, peculiar observable actions. Psychologists can also provide crisis intervention services and correct deficits in cognitive, social, and instrumental functioning to enhance independent living skills and appropriate interpersonal interaction and communications of mentally disabled individuals.

Psychologists provide services to elderly and chronically disabled individuals in many settings, including community mental health centers, mental health clinics, hospitals, nursing homes and other long-term care facilities, senior centers, and hospice programs. In addition, over 1400 psychologists are on the faculty of medical schools, providing training to future physicians. However, a 1982 survey identified only 0.6 percent of a representative sample of APA members (considered to be representative of the nation's doctoral psychologist provider population) involved in health service delivery focused on the elderly (i.e., 70% or more of their clients were age 65 or over). The same survey revealed that the elderly comprise some portion (11-70%) of the caseload for an additional 1-2 percent of the nation's psychologists. If we apply this 2 percent figure to the current population (47,000) of service providers, it would mean that less than 1000 psychologists would be significantly involved in this type of service provision to the elderly.

A PROPOSAL FOR IMPROVING THE MEDICARE MENTAL HEALTH BENEFIT

The improvement of the Medicare mental health benefit is long overdue. A number of options have been proposed, but the majority focus on simply an increase in the amount of reimbursement allowed for currently covered services, not in modifying the allowable professionals who may deliver services. This approach not only provides a partial solution to the problem, but also further exacerbates the adverse consequences of limiting service provision to physicians. Furthermore, psychologists are accorded independent standing in all other federal health care programs, including the Civilian Health Care and Medical Program of the Uniformed Services and the Federal Employees Health Benefits Program, in the Medicaid plans of 28 states, and in private health insurance plans across the country. It is sound policy to extend this same standing to Medicare enrollees to enable them to have the same access to psychologists' professional services as persons under the age of 65 now enjoy in other health insurance programs.

The following proposal would enhance the Medicare benefit by adding a simple pro-competitive feature to ensure better access and improvements to mental health services for the elderly and disabled under Medicare. We urge your support of this proposal:

Specifications for Pro-Competitive, Cost-Effective
Improvement of the Medicare Mental Health Benefit

- o Extend eligibility for Medicare reimbursement to psychologists for their services by adding "psychologist acting within the scope of his or her license" to the definition of "physician" in Section 1861(r) of the Social Security Act.
- o Define eligible psychologists as those who are licensed or certified, meet specific educational criteria, and agree to accept assignment for Medicare claims.
- o Give the Secretary of Health and Human Services (HHS) the authority to set reasonable charge levels or fee schedules for all psychotherapy services which take into account the current prevailing charges for psychiatrists and the historically lower fees of psychologists.
- o Control utilization and quality by authorizing the HHS Secretary to require that mental health services be subject to utilization review by entities having special expertise in case management of mental health services.

Thank you for the opportunity to present testimony regarding our concerns for existing gaps in Medicare that are not addressed in current proposals for protection from catastrophic costs. We urge the Subcommittee to use this opportunity to address the mental health needs of the elderly and disabled Medicare population.

STATEMENT OF THE
AMERICAN SOCIETY OF INTERNAL MEDICINE
TO THE
COMMITTEE ON WAYS AND MEANS
ON
CATASTROPHIC HEALTH INSURANCE

ASIM is a federation of state component societies of internal medicine with over 20,000 members who, by training and practice standards, are recognized as specialists in internal medicine and its subspecialties. The vast majority are in direct patient care. Due to the nature of the specialty, internists have a broader perspective on our health care delivery system than other groups of physicians. Most deliver all levels of care -- in the office, in the hospital, and in extended care facilities. It is important to share this broad perspective as it relates to the proposals before this committee.

According to a recent study by the National Center for Health Services Research, nearly 16 million American families, or about one family in five, incur catastrophic out-of-pocket medical costs each year. Catastrophic costs were defined in the study as those out-of-pocket expenses that: 1) are not covered by private or public health insurance or by Medicaid or other government programs; and 2) exceed 5 percent of a family's gross income. The study revealed that families suffering catastrophic costs were of two types: 1) families that had good insurance coverage but incurred large costs beyond that coverage and 2) low-income families with inadequate health care coverage whose out-of-pocket expenses were small but burdensome in relation to their income. ASIM believes that no American should suffer financial disaster because of the cost of health care and supports the availability of coverage to provide protection to all Americans against financially catastrophic medical problems. As early as 1974, ASIM publicly supported the concept of catastrophic health insurance. Later, the Society testified in support of the "Catastrophic Health Insurance and Medical Assistance Reform Act" before the Senate Finance Committee in March 1979.

The Administration Proposal

The Society is encouraged by the considerable interest of the Administration and Congress in formulating a national health policy to address the problem of affordable catastrophic insurance coverage for older Americans. Although the Society is supportive of the Administration's proposal (S. 592/H.R. 1245), based on earlier recommendations of Secretary Bowen to expand Medicare to cover the cost of catastrophic illness through a monthly Part B premium, ASIM has reservations about financing the benefit solely through higher premiums applied equally to all beneficiaries enrolled in Medicare Part B. This aspect of the Administration plan will adversely affect low income beneficiaries and require Medicare beneficiaries to bear the full cost of the catastrophic benefit. ASIM encourages members of this committee to consider modifications to minimize the impact on low income beneficiaries through such mechanisms as: 1) increasing Part B premiums for higher income beneficiaries only; 2) increasing hospital coinsurance for higher income beneficiaries only; 3) varying the catastrophic cap by income; and 4) as a last resort if other financing mechanisms are insufficient or not politically acceptable, taxing the actuarial value of Part A and Part B benefits, as proposed by Representatives Stark and Gradison.

In 1984, ASIM addressed the issue of catastrophic coverage for the elderly as part of a study to identify reasonable and practical approaches to restoring the solvency of the Medicare program. In the report, ASIM addresses a number of the recommendations discussed above, including the establishment of an income-related cap on beneficiaries' out-of-pocket costs for covered services (Medicare's Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) combined) and increasing hospital coinsurance and/or premiums for those beneficiaries who can afford to contribute more to the cost of their care. An income-related cap on out-of-pocket expenditures would result in considerably more protection for catastrophic illnesses than would be available to beneficiaries through the Administration plan (which sets a cap on out-of-pocket expenses for everyone at \$2,000) since the cap would be set at a level that reflects a reasonable definition of "catastrophically" expensive illness, based on ability of each beneficiary to contribute out-of-pocket for necessary care.

ASIM's 1984 solvency paper cites several ways that the Congressional Budget Office (CBO) believes that premiums could be varied by income (CBO, Changing the Structure of Medicare Benefits: Issues and Options, March 1983). Although the CBO numbers may need to be updated, the report provides two feasible examples of how this proposal may be implemented. CBO proposed one option that would require single persons with incomes above \$25,000 and couples with incomes over \$32,000 to pay 30 percent of SMI costs. (Currently the proportion of the Part B costs financed by enrollees is set at 25 percent of program costs.) CBO projected additional revenue of \$1.7 billion over a 5 year period. A second option suggested by CBO would require single persons with incomes above \$25,000 and couples with incomes over \$32,000 to pay 35 percent of SMI costs. The Medicare program would accrue \$2.7 billion in additional revenue over a five year period under the second option.

To further shield low income beneficiaries from excessive out-of-pocket expenditures for medical care, ASIM believes additional funding mechanisms should be considered by the committee that spread the responsibility for financing the new benefit to groups outside the beneficiary community. Those modifications could include:

- o Increasing the excise tax on alcohol and tobacco and dedicating at least a portion of the revenue to Medicare. Doubling the cigarette excise tax from 16 cents to 32 cents per pack would produce \$3.3 billion in new revenues in FY 88; and
- o Imposing the Medicare payroll tax on currently exempt state and local government employees. This option would produce as much as \$1.6 billion in revenues per year.

Developing Financial Protection For Long-Term Care Costs

The Society believes that the Bowen/Administration plan is a significant step forward, but that it still does not go far enough, since it is silent on the issue of catastrophic coverage for nursing home care, community-based services and chronic illnesses requiring long-term care. Although the Society believes the committee should consider ways to provide catastrophic protection for chronic and long-term care expenditures in addition to expenses related to long hospital stays, ASIM understands that developing appropriate ways to finance long-term care may entail considerable study. Therefore, ASIM can support a catastrophic proposal that includes coverage for acute care only, while recognizing the need for future consideration of ways to expand coverage for long-term care. The Society is currently studying the issue of long-term care and will be offering its own recommendations to the committee in the future.

Among Medicare beneficiaries, the most critical need for catastrophic protection is for expenses associated with long-term, chronic illness. Of those beneficiaries who pay more than \$2,000 per year for medical care, 80 percent of the expenses incurred are for nursing home care. Medicare currently pays for only limited stays in nursing facilities (Medicare paid for less than 3 percent of expenditures for nursing home care in 1985). The principal source of government financing for long-term care is Medicaid, the federal-state health care program for the poor. But to qualify, elderly persons must first exhaust all resources.

The use of Medicaid to pay for the long-term needs of Medicare patients has put considerable pressure on funds available to support the non-Medicare population living near or below the poverty line. For those without insurance, any significant illness is generally catastrophic. Economic pressures, coupled with health care cost containment efforts and the lack in federal funds for health care programs has created an environment in which more persons have found themselves without either health insurance or coverage under existing state or federal medical assistance programs. For example, the percentage of the non-elderly population without health care increased from 14 percent in 1979 to 16.5 percent in 1983, according to the Employee Benefit Research Institute. During this time, however, there also was a decrease in the percentage of the population that was able to qualify for Medicaid. In 1975, 63 percent of low-income people were eligible for Medicaid, compared to 40 percent in 1983.

The lack of private long-term care insurance and adequate personal resources will continue to force individuals to risk financial devastation in the event of long-term care. Moreover, the number of uninsured and underinsured Americans continues to grow, with as many as 37 million persons being without adequate coverage. Consequently, discussions of the catastrophic care problem must not only focus on the acute care

expenses of the elderly, but must extend to the long-term care costs and other catastrophic expenses incurred by all Americans. ASIM supports the concept that employers make available a minimum benefits package to all employees. The Society will be providing the committee in the future with recommendations on how this can be accomplished, on the types of benefits to be included in the minimum benefits package offered by employers, and on the advisability and feasibility of expanding Medicare's proposed catastrophic benefit to include benefits for currently non-covered services, such as prescription drugs.

ASIM also believes that adequate health insurance for a significant portion of the uninsured and underinsured could be provided through the establishment in each state of a risk pooling program in which all health care underwriters in a state participate. The tax code should be amended to ensure the participation of self-insured groups, by requiring such participation as a condition for deducting the costs of health insurance coverage as a business expense. The risk pool would be open to both the medically uninsurable and standard risks who lack access to group coverage.

Conclusion

In conclusion, ASIM welcomes the opportunity to work with the committee in developing a proposal to protect the elderly and others in the future from catastrophic health care costs. The Society also requests that the committee carefully review ASIM's report on restoring the solvency of the Medicare program, which is appended to this testimony, and include it in the official record of the hearings on the subject. Congress should specifically consider modifying HR 1245 to vary beneficiary out-of-pocket contributions and the catastrophic cap by income and to obtain additional revenue from sources other than beneficiaries themselves.

ASIM expects to be providing the committee with additional recommendations in the future on such issues as:

- o financing long-term care through the private and/or public sector;
- o implementing public and private sector initiatives to reduce the number of uninsured (e.g. by providing incentives for employers to offer a minimum benefit package for all employees);
- o the advisability and feasibility of expanding the benefits offered through Medicare's proposed catastrophic plan to include currently non-covered services such as prescription drugs and an expanded home health care benefit; and
- o the types of benefits that should be included in minimum benefits packages offered by employers.

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C / S / E CITIZENS FOR A SOUND ECONOMY

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HEALTH CARE SAVINGS ACCOUNTS: A CURE FOR MEDICARE'S ILLS

by
Michael Becker

EXECUTIVE SUMMARY

Since 1970, annual spending on Medicare has increased from \$6.2 billion to \$65.8 billion. It is estimated that by the year 1995, Medicare's Hospital Trust Fund will have a deficit of \$400 billion. By the time those now entering the work force retire, payroll taxes for Medicare will have to rise from their present 2.9 percent to between 7.4 and 15.4 percent just to maintain current benefit levels.

The chief contributing factor is the skyrocketing cost of medical care. On average, the government pays \$9600 for every patient hospitalized under Medicare. The reason for this is simple: since the government pays much of the bill, neither patients nor doctors worry much about the cost of care. They feel free to extend hospital stays and run unnecessary tests regardless of cost effectiveness.

There is a better alternative, one which could gradually lessen government involvement in the provision of health care insurance. It is embodied in H.R. 3505, a bill initially sponsored by Reps. French Slaughter (R-VA), Philip Crane (R-IL), David Dreier (R-CA), and Mark Siljander (R-MI) and currently cosponsored by 34 other members of Congress. H.R. 3505 creates Health Care Savings Accounts (HCSAs), which allow individuals to take a 60 percent federal income tax credit on an amount equal to Hospital Insurance payroll tax paid. Upon retirement, these funds could be used to provide health care. Such a mechanism would give individuals control over their own health care and end the trend toward socialization of health care in the United States.

INTRODUCTION

Health Care Savings Accounts (HCSAs) present a way of solving the myriad problems of Medicare in particular and the health care industry in general. They put control of medical care back in the private sector and put responsibility for paying medical bills in the hands of those receiving care. This will help control spiralling health care costs.

HCSAs permit individuals to voluntarily exchange Medicare benefits for tax credits. Individuals currently pay 1.45 percent of income in hospital insurance (HI) payroll taxes, and employers contribute an equal amount. In exchange for a higher Medicare deductible upon retirement, individuals would be permitted to put into an HCSA an amount equivalent to the full 2.9 percent HI payroll tax and receive a 60 percent tax credit. Upon retirement, an individual would have accumulated thousands of dollars in the savings account which can be used to pay medical bills.

The need for HCSAs has never been more urgent. It is reflected in the symptoms of what can be described as a crisis in the health care industry: skyrocketing costs, reduced quality of care, increased regulation of patient-doctor relationships, insufficient catastrophic and long term custodial care insurance, and the impending bankruptcy of Medicare. The problem in each case can be traced to government involvement. HCSAs represent a solution to each of these problems.

THE PROBLEM

The Medicare system consists of two components: Hospital Insurance (HI) and Supplemental Medical Insurance (SMI). HI is financed through a 2.9 percent payroll tax and pays for up to 90 days of hospital costs annually, subject to a \$492 deductible and co-payments of \$123 a day for days 61 to 90. For hospital stays over 90 days, each person has a lifetime reserve of 60 days at \$246 per day. SMI is a voluntary program with a subsidized premium which pays for such things as physician and out-patient services subject to deductibles and co-payments. Currently, SMI's premium covers only 25 percent of the costs of the program, with the difference made up out of the government's general revenues.

From its inception, Medicare has contributed to the explosion in health care costs. The reason is simple: since the government paid much of the bill, patients did not worry about the cost of care. Doctors, reacting to this situation, felt free to extend hospital stays, run unnecessary tests, and in general ignore questions of cost effectiveness.

These incentives are reflected in skyrocketing increases in the cost of medical care. Federal outlays on Medicare have risen from \$6.2 billion in 1970 to \$65 billion in 1985.¹ On average, the government spends \$9600 on every patient hospitalized under Medicare.² Total spending on health care took up 10.6 percent of GNP in 1984 compared to 6.1 percent 20 years previously.³ As a result, the average family of four runs up \$6300 in medical bills each year.⁴

The problem is largely due to the fact that third parties, rather than the individual who receives the care, pay medical bills. Third parties pay for 71 percent of all medical care.⁵ To a considerable extent this is accounted for by government expenditures. But the government also fosters third party payments with the tax-exempt status of fringe benefits, which encourages provision of health care through another third party, private corporations. It is easier during negotiations to give in on non-taxable contributions to medical care than on wages. Much of this coverage provides the same perverse incentives that exist with Medicare. Chrysler, for example, found that health care benefits accounted for one-tenth of its cost of production in building the K-car.⁶

Symptomatic of the problem is the introduction in recent years of costly new technologies. Technology is often cited as the explanation for rising costs. However, in most industries, new technologies are introduced because of their potential for cost savings. In the medical industry, the government seems ready to pay whatever bills hospitals charge, so hospitals feel free to invest in expensive technology which would otherwise be impractical.⁷

In an attempt to reduce escalating Medicare costs, the government introduced the Prospective Payment System (PPS) in 1983. Under PPS, fixed rates are set for 468 diagnosis related groups (DRGs), a classification of different diseases. Upon a patient's discharge, hospitals are paid the rate applicable to the particular disease. If the hospital's costs in treating the patient are less than this rate, it can pocket the difference as profits; if more, it takes a loss.

PPS has reduced cost increases. Obviously, since a hospital's profits depend on holding costs below the rate set by the government, there is an incentive to economize. This is reflected in numbers which show both lower costs and increased pressure to reduce unnecessary care. Hospital cost inflation dropped from 11.6 percent in 1980 to five percent in 1985. While this might be explained by the general drop in inflation, it is instructive to note that medical costs not covered by PPS, such as physician fees, are still increasing at double digit rates.⁸

The Department of Health and Human Services (HHS) has noticed the difference. In 1983, HHS estimated that HI expenditures would be \$51.1 billion. With PPS, actual outlays turned out to be \$48.7 billion.⁹¹⁰ An even more telling statistic is that the average hospital stay for Medicare patients dropped from 9.3 days in 1983 to 7.7 days in 1985, reflecting the increased profitability for hospitals of treating and discharging patients as fast as possible.

This drop in costs, though, provides a distorted picture of what is going on. The increase in regulation attributable to PPS has increased the level of paperwork. On the average, 25 percent of every hospital bill is due to the costs of paying clerks and computer operators to fill out paperwork to comply with regulations.¹¹ Under PPS, the per unit cost of service has gone up; federal expenditures have fallen because the quantity of services provided has been reduced. Pointing to the level of government expenditures, though, the bureaucracy has been able to declare PPS a success. HHS is now looking for ways to expand PPS to include hospital capital costs and physician fees.

This "success" of PPS is further clouded by charges of reduced quality of care. If a hospital is paid a set fee per DRG regardless of the amount of service, it has an incentive to cut costs by cutting services. Once a patient has been admitted and diagnosed, any additional care is, in a sense, an act of charity because the hospital's payment has already been set. In effect, a hospital makes profits by not doing things.

"Horror" stories about the effects of PPS are beginning to accumulate. In New Jersey, one hospital voted to use the cheapest pacemaker available in patients with the shortest life expectancies, a practice which one doctor labelled "euthanasia by DRG."¹² Another patient was examined by his family practitioner for chest pains and, when his tests came up negative, was sent home for fear that Medicare would deny payment in that case. The next morning he was brought into the emergency room and died. The doctor was quoted as saying, "I feel terrible about the case. I would have admitted him the day before except for those DRGs."¹³ In some cases hospitals have falsely told their patients that Medicare will not pay for costs above the fixed fee.

As the government grapples with the dilemma of reducing costs without affecting the quality of care, it increases regulation and control of the medical industry. Under Medicare, for example, a patient is forbidden from paying an extra amount above the PPS designated fee in order to get better care; any patient who attempted to strike such a deal would find that Medicare would withdraw all payments. The government is preventing patients, hospitals, and doctors from reaching mutually

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beneficial agreements. This is, in effect, a price control. As is the case with all price controls, surpluses and shortages develop when the fixed fees differ from the market rate. Diseases are now being labelled "winners" and "losers" depending on whether the fee is set too high or too low. Hospitals seek out patients with "winning" diseases and reduce service for those with "losing" diseases.

The government is becoming more directly involved in medical decisions as it tries to control the unintended consequences of the perverse incentive structure it set up. As part of the PPS cost controls, the government has become more stringent on accepting admissions. Most hospitals have to get permission from Medicare before they admit patients under the program.¹⁴ Again, horror stories can be told of the consequences of bureaucrats refusing to certify admissions.

For example, one elderly man with Alzheimer's disease became dehydrated and unconscious. Medicare decided on a "retrospective denial"; that is, they announced after he was admitted to the hospital that they would not pay the bill. The patient was sent home -- still in a coma -- and died a few days later.¹⁵ In another case, a man called his doctor about his ailing wife and was told that Medicare approval would take several days. He insisted on taking her to the hospital anyway. She was found to have pneumonia and a bowel obstruction. In several days, she would have been dead.¹⁶

The government has looked into the problem of quality of care. By and large, though, official conclusions offer little hope. The Senate's Special Committee on Aging recommended increased government monitoring and oversight of medical care. But more regulations will only create more negative unintended consequences and lead to more commissions in the future to solve the problems created by previous recommendations.

The problem rests in the government's role as payer. As long as the government pays the bills, incentives to cut costs will not exist unless the government imposes stifling regulations -- in which case a doctor's traditional freedom to care for his patients is replaced by the doctor looking over his shoulder for the bureaucracy's approval. The problem can be summed up in one question: who is to regulate the regulators? The answer lies in giving control of medical care back to patients.

CATASTROPHIC COVERAGE

In his State of the Union speech, President Reagan requested a study of the problem of catastrophic coverage. His adminis-

tration established working groups to consider adding catastrophic coverage to Medicare.

The reason for the interest is that Medicare has many "gaps" which can lead to the runup of a considerable medical bill outside of its coverage. One obvious case is a patient whose hospital stay is beyond Medicare's 90 day limit. But even hospital stays under 90 days can build up quite a bill; for example, a 70 day hospital stay would mean \$1722 in deductibles and co-payments, not including additional co-payments under SMI.

Private insurance policies ("Medigap") have been created to fill this gap. Seventy percent of the elderly now have some supplemental private insurance which typically covers deductibles and co-payments incurred under Medicare along with the costs involved with hospital stays over 90 days. (These supplemental private insurance policies are commonly being pitched by Danny Thomas and Lorne Greene through TV ads.) As a result, most people are adequately covered against "acute catastrophic illnesses" -- illnesses which involve costly hospital stays.

At present, however, neither Medicare nor Medigap policies cover chronic long-term custodial care involving nursing home care or other non-institutional services. Currently, for those aged who spent more than \$2000 out-of-pocket, 81 percent of their additional expenses were for nursing home care.¹⁷ Between 1975 and 1980, nursing home expenditures grew 105 percent compared to a 53 percent growth in the CPI.¹⁸ Approximately one-half of the financial support for long term care comes from the government through Medicare and Medicaid.¹⁹ Medicare, however, pays only for care following a hospital stay, and this only covers 100 days a year with a \$50 co-payment after day 20. Medicaid can only be acquired once the elderly have impoverished themselves via health care expenses.

Private insurance firms, on the other hand, have faced several problems in insuring long term health care. The definition of long term health care itself has presented a problem.²⁰ Long term health care does not necessarily mean nursing home care. For people whose mental and/or physical conditions are such that their normal functioning is impaired, services such as chores around the house, guidance in emotional problems, nutritional education, personal care services, and speech therapy would be included along with skilled nursing care in a definition of long term health care.²¹ The problem for insurance companies is that many custodial care activities such as bathing, dressing and feeding a person are difficult to classify as insurable events.

Many of the problems with long term care can be attributed to government involvement in the medical industry. The biggest

problem is adverse selection where only those in the high risk population choose to make provision for nursing home care. Adverse selection may be due to low-risk individuals' perception that Medicaid and Medicare will handle the problem. A Gallup Poll found that 79 percent of respondents believed that Medicare pays for long term care in a nursing home.²² Medicaid is already viewed by many as a national program for long term nursing home care. The effect is inadequate savings on the part of individuals to either pay for nursing home expenses themselves or to create an effective insurance market for long term care.

Whether the insurance industry will be able to solve the actuarial problems with long term care insurance is unknown. The few nursing home insurance plans which are now available appear to be poor bargains.²³ At this time retirees would be far better off saving the money they would otherwise spend on premiums. Current insurance plans provide only three to five years of coverage -- little financial risk is avoided by buying insurance which, if you enter a nursing home at age 66, leaves you without coverage after age 70.

It is possible that the complexities and difficulties in insuring long term care will always make self-insurance through savings the best financial path for individuals to follow. Obviously self-insurance is not without its own potential risks and costs. However, other factors might offset this. For example, while no doubt a disease which leaves an individual disabled in a nursing home can be financially devastating, the probability of needing nursing home care is low. Only five percent of the population aged 65 and over are in nursing homes, and the probability that an individual will enter a nursing home between the ages of 65 and 74 is only one in 100.²⁴ If an individual aged 65 saved money in an interest bearing account instead of paying out tens of thousands in long term care insurance premiums, by the time he reached the age of 85 he will have accumulated enough in the savings account to provide the same amount of coverage that would be provided in the insurance plan.²⁵ It is over the age of 85 that the odds of needing nursing home care begin to rise substantially (one out of five). By saving, the individual would have the flexibility to spend the money on the variety of potential needs which fall under the definition of long term care, unlike the more "narrow" coverage provided typically in current nursing home policies. The other difference between saving and buying insurance is that, should nursing home care ultimately be needed, the same amount of coverage can be gained either way, but should nursing home care not be needed, the money spent on insurance is lost. A savings account preserves that money for other uses, including passing it on to heirs.

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Of course, the possible inadequacy of insurance now says little about possible insurance plans in the future. The market is a complex one with many actuarial challenges. It is, however, a potentially lucrative market, and insurance companies are exploring ways to make entrance actuarially sound.

FINANCING MEDICARE

Lurking behind all of these problems is the fact that the HI component of Medicare is likely to go bankrupt sometime in the 1990s.²⁶ The cumulative deficit in HI will reach \$400 billion between now and 1995.²⁷ Cost savings under PPS hardly seem sufficient to overcome this problem. Like Social Security, funding for HI is the equivalent of a pyramid scheme which must eventually collapse. However in the case of HI, the potential of the bubble bursting is much more imminent.

It is estimated that by the time those now entering the work force retire, payroll taxes will have to be raised from their current 2.9 percent to somewhere between 7.4 percent and 15.4 percent just to cover Medicare's costs.²⁸ This suggests the futility of proposals to solve the problem through payroll tax increases. Such tax increases would have a devastating effect upon the economy while failing to deal with Medicare's fundamental problems.

CURRENT PROPOSALS

The current situation can be summarized as follows: The government has set up a program to pay for medical care for the elderly which does not cover the main potentially catastrophic expense for the elderly, long term health care, and does such an inadequate job of paying for hospital care that individuals feel compelled to take out supplementary private insurance.

Most proposed "solutions" to the problem of catastrophic coverage offer little constructive change. The one group which has been successful in meeting consumers' needs is insurance companies which have rushed in to provide badly needed service. However, rather than looking for private sector solutions most reform proposals involve either replacing Medigap with an extension of the Medicare system or expanding Medicare to include long term care or both.

Many of these proposals embody the same basic principles. There is some recognition of inadequacies in the current Medicare system both in terms of coverage and the effects of government regulations on the quality of care. Despite this the substance of these proposals is largely counterproductive. Generally

speaking they propose putting a cap on individual medical expenses and calling everything above the cap "catastrophic expenses," attempting to undercut Medigap with a bigger Medicare program, and increasing government monitoring of medical care. These proposals offer little hope of reducing costs. They do nothing to increase the role of the individual in making health care decisions. More government regulation will mean more bureaucratic horror stories and increased regulatory costs.

Within the HHS bureaucracy is a proposal which would create a third catastrophic care component of Medicare to go with HI and SMI. The idea is to have a voluntary catastrophic coverage program which would be fully paid for via premiums, provide coverage for unlimited periods, and put a cap on co-payments. This proposal operates on the premise that Medigap policies are a "ripoff" and that the government can undercut Medigap premiums.

The underlying premise is wrong for two reasons. First, Medigap policies provide more extensive services than those contained in current proposals. Understandably, higher premiums accompany higher levels of service. Second, the proposals ignore likely adverse effects. Well-meaning government officials may intend to provide medical insurance more efficiently than the private sector, but good intentions are never enough. The costs of programs are usually underestimated. Medicare was originally estimated to cost \$4 billion by 1980; it actually cost eight times that much.²⁹

Analysts within the HHS bureaucracy assume a static world in which individuals will use health care in excess of the 90-day limit regardless of whether they or the government pay the bills.³⁰ HHS also assumes no marketing costs. Their experience is with SMI, which is heavily subsidized and therefore easy to sell. A catastrophic premium covering 100 percent of costs and competing against private insurance would cost a considerable amount of money to promote.³¹ A likely scenario is that powerful political interests would prevent administrators from charging premiums to cover the full costs of insurance. Private insurance companies would have to compete against taxpayer-subsidized rates, as is now the case with SMI.

A Harvard University group has recommended another proposal which would expand Medicare to include nursing home care. The price tag the group puts on their proposal is \$50 billion,³² an outlay which would virtually double Medicare's budget. What would we get for a \$50 billion expenditure? Probably a bigger mess than the current Medicare problem. Insuring long term care is a complex matter. The fact that the private sector is struggling with the difficulties is not a case for government involvement; in fact, the opposite is true. The skyrocketing costs and suffocating regulations which have characterized

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current Medicare coverage would now be introduced to long term care. It is a safe guess that the \$50 billion in estimated costs are understated, given the historical tendency of Medicare costs to vastly exceed original projections.

Furthermore, none of these proposals for expanded government involvement does anything to address the problem of the impending bankruptcy of Medicare. Instead, they seek to expand government spending and control over the medical industry.

HEALTH CARE SAVINGS ACCOUNTS

Any true solution to the current dilemma must increase the role of the private sector. In particular, individuals must become more directly involved in planning for and paying their own medical expenses upon retirement.

Reps. Slaughter, Crane, Dreier, and Siljander have cosponsored a bill, H.R. 3505, which would allow individuals to take out Health Care Savings Accounts. HCSAs would gradually reduce the government's role in medicine, create funds for catastrophic insurance, and solve the financial problems of Medicare. To date, 34 other members of Congress have signed on as cosponsors.

What are HCSAs?

HCSAs could be operated in a manner similar to that in which IRAs are currently run. One would be allowed to contribute to an HCSA an amount up to the amount paid by oneself and one's employer in HI payroll taxes. For example, if a worker paid \$500 in payroll taxes and the employer also paid \$500, an individual would be allowed to contribute \$1000 to an HCSA. An income tax credit of 60 percent could be taken on the amount put into the account. In the previous example, if the individual put the entire \$1000 into the HCSA himself and would otherwise pay \$2000 in income taxes, he can subtract the tax credit of \$600 (60 percent of \$1000) from his income tax liability and therefore would pay only \$1400 in income taxes. Alternatively, the individual could have the employer enter the amount and the employer would then take the tax credit.

In return, an individual will have his Medicare HI deductible raised by an amount based on the amount he contributes to his HCSA. Consider an individual earning an average income over a 45 year working career. He begins working at the current average income of \$17,000. Assuming a seven percent real rate of return³³ and a three percent growth in real wages, this person would accumulate \$227,000 in the HCSA if the maximum allowable amount were contributed annually. (All numbers in this example are in 1986 constant dollars. Inflation will make the nominal

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amounts higher.) This is sufficient to provide a \$23,000 annuity. The accompanying annual deductible, in this case, would be \$6800.³⁴ The annuity would be more than sufficient to purchase private insurance against this deductible. It would also be more than sufficient for self-insurance.

Sixty percent of HCSA funds (representing the tax credit) would be allocated to health expenditures. The other 40 percent could be used for whatever other purpose the individual desires, much like an IRA. In addition, if an individual is able to conserve on health expenditures, he could also spend the excess of a specified proportion of the 60 percent each year however he wishes.

Individuals participating in HCSAs to a certain minimum degree would be eligible for catastrophic coverage under Medicare. As it currently stands, individuals do not receive catastrophic care under Medicare. The catastrophic level would be set as the amount above the deductible. Individuals who met certain requirements, such as contributing to HCSAs for ten years, would be eligible.

The program would be entirely voluntary. Individuals can choose to remain on the current Medicare system. Provision is made for poor people for whom the amount in HCSAs and from other sources may be inadequate to pay the deductible. Upon an individual's death, the funds in his HCSA would be transferred to his heirs. The tax credit comes from general revenues, not the HI Trust Fund, so resources will exist for those who choose to remain on Medicare.

Returning Medical Care to the Private Sector

HCSAs help overcome the dilemma now facing the government of skyrocketing costs and reduced quality of care. With deductibles in the tens of thousands of dollars, individuals -- not the government as a third party -- will be spending the money. Individuals will then be free to choose the level of services and care for which they are willing to pay. Frugality would be rewarded and rising costs due to the government's willingness to pay whatever it is charged would be curtailed.

For those individuals who choose private insurance, it is proper to note the difference between a private insurance firm and the government as a third party payer. Insurance firms face the same "third party" problems that the government faces. However, insurance companies deal with them more effectively because they face a different incentive structure. The Medicare system is a monopoly; individuals are forced to pay payroll taxes, regardless of whether they want to be covered by Medicare or not. On the other hand, if a private insurance firm is

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careless about costs and tries to cover its carelessness by charging higher premiums, it will be undercut by competitors and lose its business. In this spirit, private insurance firms are currently experimenting in a competitive environment for ways to reduce the costs inherent in being a third party payer. Additional funds made available through Health IRAs will accelerate this process.

Development of individual insurance coverage has been inhibited by several factors in addition to Medicare and Medicaid. First, much of the role has been taken up by private corporations, which replace wage increases with increased medical benefits because of favorable tax treatment for the latter. Often such firms will decide to self-insure. Obviously, an individual who is insured through work will not need to take out separate health insurance. Second, Blue Cross/Blue Shield's control over the marketplace has made it difficult for private insurance companies to enter. Blue Cross/Blue Shield is a non-profit, quasi-public firm enjoying considerable tax and regulatory advantages which are hardly conducive to creating a competitive cost-minimizing environment. The fact that private insurance companies survive in the marketplace despite "The Blues'" advantages suggests that the private companies are considerably more efficient. Eliminating Blue Cross/Blue Shield's preferences would enhance the competitiveness of the industry and the effectiveness of HCSAs.

It is difficult to describe in detail the potential result of a competitive environment in the health care insurance industry, since the competitive process itself will reveal the efficient structure of health insurance. For example, the debate over whether fee-for-service or prepaid group plans (such as HMOs) are more efficient can only be decided by market competition between the two alternatives. One might expect deep discounts in premiums for individuals willing to accept high deductibles not only because deductibles make individuals pay part of their bills but also because they give individuals incentives to economize on health care. The possibilities are endless.

The commercial insurance industry has also tried other approaches. One example is Preferred Provider Organizations (PPOs) in which insurance companies motivate their patients to choose hospitals with lower charges. Sometimes this involves contracting with a hospital for discount rates in exchange for increased business. One can imagine such possibilities as discount insurance premiums for those who promise to choose the low cost alternative.

One additional (and perhaps most important) point is that HCSAs present the opportunity to reduce an ever-increasing web of

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government regulation of medical decisions. With patients paying their own way, either out of their own pockets or indirectly through insurance, both doctors and patients will regain their traditional control over the costs and level of care without having to seek the approval of a government bureaucracy.

HCSAs and Catastrophic Care

One of the most appealing aspects of HCSAs is that, unlike other proposals, they provide a solution to the problem of chronic long term care. Whether or not the actuarial problems are solved, the money in the account represents a considerable sum which can be drawn on in case of a catastrophic illness requiring nursing home care. It was suggested earlier that saving for nursing home expenses during retirement may be more efficient than buying insurance. If that is the case, HCSAs represent a perfect vehicle for doing just that. At present custodial rates, a year of care can be purchased for about \$17,500³⁵, far less than the \$23,000 annuity presented in the example earlier which the average person would have coming from their HCSA savings. Note that these expenses assume a "worst case" scenario -- it assumes an individual would be forced to enter a nursing home at age 65. More likely, annual medical expenses will be only a fraction of the annuity, and this money can be saved for health expenses later in life or for other retirement activities.

In addition, the billions of dollars in HCSAs provide a pool of funds which could be used to solve the actuarial problems of private insurance for long term care. Adverse selection would probably be less of a problem with a population owning HCSAs. Individuals would be more aware of the need to insure against long term care, and 60 percent of HCSA funds will be committed to medical expenditures of some sort. The low risk pool of individuals from age 65 to 74 would be looking for an outlet for their health care expenditures and therefore would be likely to consider long term care insurance. The uncertainty surrounding the demand for insurance would be alleviated, since billions of dollars would exist to be invested. This sum of money would represent a clear future effective demand for insurance. This could help overcome the "Catch-22" aspect of long term care insurance where only high risk individuals are interested in insuring themselves. Defining the insurable event would remain a challenge, but the potential lucrative market should provide insurance companies with an incentive to solve the problem.

Inequity in Medicare

HCSAs also redress current inequity in the Medicare program. Medicare discriminates against blacks and Hispanics. The average life expectancy of blacks is 64.8 years; for Hispanics, it is

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66.6 years.³⁶ This is compared to a life expectancy for whites of 74 years. Since Medicare does not start paying medical bills until age 65, these groups pay their whole life for benefits which the majority of them will not receive. With HCSAs, death before retirement will not result in total loss of benefits since funds in the account transfer to the individual's heirs.

Medicare also represents a poor deal for the current generation of workers. While current retirees receive benefits which are several times what they contributed, the expectation for workers now entering the work force is much different. A white male, age 20, can expect to pay \$8500 more in taxes than he will receive in benefits.³⁷ A black male, age 20, can expect to pay \$14,000 more in taxes than he will receive in benefits.³⁸ With HCSAs, the situation will be totally different. Individuals will earn market rates of return on amounts equal to taxes paid for Medicare and will end up with more benefits than taxes.

Averting Bankruptcy

HCSAs sharply reduce Medicare's long term financing problems. They do this without cutting the quality of care, reducing benefits, or raising payroll taxes. Future reductions in Medicare payments, as HCSAs take their place, will free up funds for the one part of medical care still left in the hands of government -- catastrophic care for acute illnesses.

HCSAs and the Deficit

One critique of HCSAs has been that they will reduce federal revenues in a period of budgetary crisis. Tax credits for the accounts will reduce government revenues, but that is not the end of the story.

First, while HCSAs might increase current deficits, reduced Medicare spending in the future will lower future deficits. Second, much of the concern over the deficit is actually over the manner in which it is financed and the concomitant effect on interest rates. Any money lost by the government because of HCSAs, though, becomes private savings. Since the supply of credit will increase by at least as much as the demand, HCSAs will probably not raise interest rates. Interest rates could even fall, since the government loses only 60 cents of revenue for every dollar deposited in an HCSA.³⁹ If the current budgetary crisis is ultimately concerned with the effects on interest rates, HCSAs will improve, not worsen, the situation.

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CONCLUSION

Twenty years of increasing government control of medical care have presented a sorry picture: costs rise, quality falls, inadequate coverage is provided, and freedom of choice is reduced. The time has come to head down a different path, a path where individuals are responsible for providing for their own care and therefore are free from government restrictions on their choices.

Health Care Savings Accounts present a way out of this bind. They solve the problem in a way that benefits everyone involved. It is an entirely voluntary program. Individuals can choose to remain on the current system if they so desire. For those who choose to take advantage of HCSAs, though, the benefits will be considerable for both themselves and the medical industry.

The government would be replacing a program in which on average it now pays out \$9600 for every patient hospitalized under Medicare with a system under which individuals on average can retire with \$227,000 to spend on medical care themselves. With this money individuals could afford to pay for their own medical care and would have an incentive to be frugal in their expenditures; every dollar saved on medical expenses would be an extra dollar which can be spent on other retirement activities. Individuals would also regain control over medical decisions which have been gradually lost to government regulators. They could seek out the quality and quantity of care they desire.

In fact, the only losers are the government regulators who will lose their control over medicine. The fight for HCSAs is a fight over who is to control the medical industry: bureaucrats or individuals and doctors. Given the overwhelming number of people who would benefit from HCSAs, the potential exists to put a considerable amount of pressure on Congress to support the plan. Ultimately, the result will be determined by whether the overwhelming number of diverse groups who would benefit from HCSAs can be marshalled successfully against the entrenched bureaucracy.

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Endnotes

1. Office of Management and Budget, Major Policy Initiatives, FY1987 Budget, p. 114.
2. This figure was calculated as follows: Spending on Medicare in FY1986 is projected at \$68.6 billion. There are 31 million individuals eligible for Medicare, of which 23 percent (or 7.13 million) received benefits. Divide \$68.6 billion by 7.13 million and the result is a little over \$9600.
3. Office of Management and Budget, FY1987 Budget, p. 5-108.
4. Cotton Lindsay, "What is the Real Cost of American Medicine?," Private Practice, November 1985, p. 9.
5. Lindsay, p. 9.
6. U.S. News and World Report, "The New World of Health Care," April 14, 1986, p. 60.
7. Of course, it can be pointed out that better technology means a higher quality of care. This might seem to contradict the argument that Medicare leads to a reduction in the quality of care. The question is, though, how best to allocate health care expenditures in order to maximize the quality of care. The heavy investment in technology might be better spent in the more common day to day care which seems to have been hurt as a result of the incentives under Medicare.
8. Major Policy Initiatives, p. 114.
9. Medicare Prospective Payment and the American Health System, Report to the Congress of the Prospective Payment Assessment Commission, February 1986, p. 11.
10. Congressional Quarterly, "Medicare Budget Facing Triple Jeopardy," Jan. 18, 1986, p. 118.
11. Jane Orient, "Who Will Control Medical Care?," Freeman, March 1986, p. 111.
12. Steven Rothman, "The Impact of Technology," Private Practice, October 1985, p. 30.
13. Story taken from Brian Sherman's "Putting PPS in Perspective," Private Practice, February 1986, p. 35.

14. Orient, p. 111.
15. Ibid.
16. Ibid.
17. Statement of Arthur Lifson before the Subcommittee on Health Committee on Ways and Means, February 25, 1986.
18. Health Insurance Association of America, "Long Term Care: The Challenge to Society," 1984, p. 2.
19. Testimony of Thomas Burke before the House Ways and Means Committee on Health, February 25, 1986.
20. The Health Insurance Association of America has the following definition for long term health care: "Long term care can be defined as a complex and interrelated array of health, health-related, and social services designed to provide preventive, therapeutic, rehabilitative, supportive, and maintenance care for individuals of all ages who have chronic physical and/or mental conditions which impair the individual's ability to function at his or her own optimal levels of mental, physical, and social functioning." See "Long Term Health Care: The Challenge to Society," p. 3. Obviously the definition covers a wide range of activities.
21. Ibid.
22. Congressional Quarterly, "Long Term Care: The True 'Catastrophe'?", May 31, 1986, p. 1227.
23. The deficiencies in the current insurance plans are pointed out by Robert Gilmour, "How to Cover the Gaps in Medicare," American Institute for Economic Research: Economic Education Bulletin, Vol. XXVI No. 5, May 1986, p. 33-35.
24. Ibid., p. 34.
25. Ibid. Of course, in the interim period the individual is less protected self-insuring than purchasing insurance. One may reasonably point out that the low probabilities involved are an irrelevant point since the whole idea of insurance is to protect oneself against financially devastating, but unlikely, financial risks. Every decision to purchase insurance, though, includes a subjective analysis of the potential costs and benefits. Nobody insures themselves against everything. The argument here is merely that, for most people, current nursing home policies have greater costs than benefits.

26. Peter Ferrara, "Averting the Medicare Crisis: Health IRA's," Cato Institute Policy Analysis, October 31, 1985, No. 62, p. 2.
27. "Solving the Problem of Medicare," National Center for Policy Analysis, p. 1.
28. Ferrara, "Averting the Medicare Crisis," p. 2.
29. Peter Ferrara, "Controlling Catastrophic Health Costs: Otis Bowen's Grand Opportunity," Heritage Background, April 3, 1986, p. 3.
30. Ibid.
31. Ibid., p. 4.
32. "Long Term Care: The True Catastrophe?", p. 1228.
33. From 1946 to 1983, the average real rate of return on all stocks on the New York Exchange was 6.9 percent. See Peter Ferrara, "Social Security: Bad Deal for Young Workers," Cato Policy Report, Vol VII No. 3, May/June 1985, p. 11. Given the boom in stock prices which has taken place since 1983, this is probably a conservative estimate.
34. These figures were calculated as follows: Life expectancy at the age of 65 is 16.4 years. Based on this, the annuity whose present value is \$227,000 would be \$23,000 (seven percent over 17 years). The calculation of the deductible goes through a different process. Under the bill, the government assumes that the savings have been accruing at the average of short, medium and long term government debt. In real terms, this has averaged two percent over the last ten years. The deductible is then calculated for the level of coverage provided by an insurance premium based on sixty percent of the annuity on the sum the government assumes is in the HCSA.
35. This figure was derived from a figure presented in "How to Cover the Gaps in Medicare," p. 34. There it was noted that four and a half years of custodial care at current rates would cost \$78,500. \$78,500 divided by four and a half is about \$17,500.
36. Frank Rogers, "Weeding Government Out of the Health Care Field," Private Practice, July 1985, p. 23.
37. "Solving the Problem of Medicare," p. 6.
38. Ibid.

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39. Of course, these funds may come from savings which had been invested elsewhere and were merely transferred into the HCSA. If this was to completely account for the individual's portion of the funds, the effect on interest rates would again be neutral. However, it is reasonable to believe that some of the money will come from shifting consumption to savings and therefore there will be increased savings relative to government credit demands due to HCSAs.

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About the Author

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Citizens for a Sound Economy Foundation

Founded in 1984, Citizens for a Sound Economy Foundation is a 501(c)(3), non-profit educational institution. CSE Foundation is affiliated with Citizens for a Sound Economy, a 501(c)(4), public interest advocacy group dedicated to returning economic decision-making to citizens. With an active membership of 250,000 citizens, CSE promotes initiatives which reduce government interference in people's economic affairs.

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Note

Nothing written here is to be construed as necessarily reflecting the views of Citizens for a Sound Economy or as an attempt to aid or hinder the passage of any bill before Congress.

TESTIMONY OF CONGRESSMAN DAN COATS

THE HOUSE WAYS AND MEANS COMMITTEE
SUBCOMMITTEE ON HEALTH

March 10, 1987

Mr. Chairman and Members of the Subcommittee, I am pleased to be a participant in this subcommittee hearing on catastrophic health insurance legislation. In fiscal year 1987 approximately 1.2 million senior citizens will have out-of-pocket expenses for acute health care that exceed \$2,000. According to this subcommittee, the figure will rise to 1.65 million in FY 88, 1.9 million in FY 89 and 2.1 million in FY 1990.

As disturbing as these statistics may be, the real story is that all of the approximately 30 million seniors in America live daily with the fear that a fall, an accident or a hospital illness could wipe them out financially. Needless to say, their families, children and grandchildren are also worried about the devastating physical, emotional and economic impact of such an illness.

That is why I am working in the House of Representatives to win passage of a program to provide catastrophic health care coverage for our nation's 30 million senior citizens age 65 or older. By paying a small monthly premium, the legislation I have cosponsored would limit seniors out-of-pocket expenses for acute medical care in any given year to \$2,000. The precise amount of the new premium has not yet been determined. But it is likely to be between \$5.00 and \$7.00 per month, and this premium will be calculated to generate sufficient revenue to pay for the new program.

It is important to note that my bill depends heavily upon the private sector. The federal government cannot and should not try to solve the massive problem of catastrophic health care alone. The state of the federal budget and the growing menace of the deficit make an exclusively federal solution unthinkable. The expertise and resources of state and local governments, insurance companies, health care providers, universities and independent researchers make them natural and necessary partners in any successful approach to catastrophic care.

My bill deals with more than acute care for the elderly because that is only one piece of the catastrophic illness puzzle. Seniors spent more than \$12 billion on nursing home care in 1984, according to the Department of Health and Human Services (HHS), or just over 40 percent of their out-of-pocket health expenses. HHS states that 21 percent of the elderly were nursing home residents in 1985. To get an idea of what these figures mean to an individual, consider that half of nursing home patients stay three months and the average cost of this much nursing home care is \$5,500.

Add to these numbers the facts that the need for long term care increases sharply with age, that life expectancy is steadily rising and that the elderly population will double in the next 45 years and it is clear that long term care is an even bigger problem for seniors than acute care.

Unfortunately, studies show that most people do not realize that Medicare does not cover nursing home care. This false impression must be corrected among both seniors and people under 65. One promising idea for addressing long term care needs is to encourage people to save for it. This idea cannot work if people believe Medicare will take care of their nursing home needs.

My bill expands the availability of long term care in two ways. First of all, it commits the federal government to work with the private sector to educate the public about the costs, risks, and financing options available for long term care.

Secondly, this bill tests the feasibility of changing the tax code to encourage IRA-like savings accounts for long term care and tax incentives to individuals and employers to encourage the development of long term care insurance.

Finally, this bill does not ignore the estimated 30 million people who are currently uninsured, all or part of a given year. The private sector is even more important in this area because no single group, especially the federal government, can muster the resources to cover the general population under age 65, and states may have ideas that are uniquely appropriate to their populations.

The plan in my bill to improve protection for the general population under 65 is to have the federal government encourage the states to explore catastrophic coverage in all employment related insurance, form risk pools for the uninsurable and require catastrophic insurance for motor vehicle registration.

My proposal is based on the recommendation of Health and Human Services Secretary Otis Bowen. I am pleased that he has tackled this issue and agreed to work with me to win passage of this legislation in the Congress. The recent endorsement of the Bowen/Coats plan by President Reagan was an added boost.

Even with Secretary Bowen's and President Reagan's support, there is much work ahead of us to win approval of this plan. But I'm optimistic we will win passage this year because of the proposal's many appealing features. Let me just highlight several of those features.

- * Because we will administer this program through the existing Medicare system, it will bring about no expansion of the federal bureaucracy.

- * This program will not disrupt current state regulation of the insurance industry.

- * This plan does not increase anyone's taxes.

- * It does not limit opportunities for the private insurance industry to provide supplemental services to cover a senior's co-insurance and deductible payment as well as the costs not covered by Medicare (such as out-patient prescription drugs, non-emergency dental work and eyeglasses).

In closing, I believe this is a plan designed to provide peace of mind protection at a very modest cost for our seniors and their families worried about an acute illness. It also begins the process of providing both long-term care and catastrophic coverage for all Americans.

Thank you Mr. Chairman for the opportunity to participate in this important hearing on catastrophic health care.

**STATEMENT OF THE
HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION
TO THE
HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH
APRIL 7, 1987
ON
HEALTHCARE COVERAGE FOR CATASTROPHIC ILLNESS**

The Healthcare Financial Management Association (HFMA) enthusiastically endorses more adequate federal financial participation in the catastrophic illness services than are now being provided. However, we caution against the creation of expectations among the public or others about funds that will be available for new and expanded healthcare services when funding of current services has such significant shortfalls. There must be adequate funds and equitable arrangements for paying for catastrophic health services.

Catastrophic illness is a significant national issue. HFMA applauds the attention being brought to this issue. The goals of covering especially difficult and costly cases, meeting long-term care needs, and protecting the uninsured and underinsured are worthy. But there are some significant downside risks for healthcare providers. Added promises to beneficiaries must be accompanied by adequate payments to the providers of the services. The government's past practices of making promises and then changing the payment rules later leaves us very skeptical.

ABOUT HFMA

HFMA is a professional membership association composed of over 25,000 individuals in 75 chapters who share an interest in financial management of hospitals and other healthcare institutions. HFMA has long been involved in the development of appropriate methodologies for paying for healthcare services. In May 1982, HFMA issued its recommendation for prospective price setting methodologies. In October 1985, we issued a statement dealing with the "Definition of and Payment for Uncompensated Services" (copy attached). In May 1986 each of our 75 chapters was asked to study the issues raised by the Secretary's Private/Public Sector Advisory Committee on Catastrophic Illness. This statement reports to you the concerns expressed by HFMA members based on their years of experience with various arrangements for paying for healthcare services.

CURRENT PROVISIONS FOR ESPECIALLY DIFFICULT AND COSTLY CASES

Especially difficult and costly cases are currently being served. These services may be covered by Medicare DRG payments, or the patient may be responsible for uncovered services, deductibles, and coinsurance.

Medicare Payments

When Medicare beneficiaries require acute care services of catastrophic proportions, these services are provided. Reportedly, only 2 percent of Medicare beneficiaries exhaust their benefits, which is rather clear evidence that catastrophic services that are covered by Medicare are being provided. If catastrophic service is covered by Medicare, payment probably involves the Medicare "outlier" provisions -- extra payments for extraordinary cases that are especially costly or lengthy. These additional payments bear little relationship to the cost of services provided. This is a seriously deficient feature of the current PPS system.

Congress has already provided the outlier mechanism for meeting some catastrophic acute care needs of Medicare beneficiaries. HCFA is distorting this provision by paying far less than Congress provided. Even though HFMA, the Prospective Payment Assessment Commission (ProPAC), and others have requested data about actual outlier payments, the Health Care Financing Administration (HCFA) has not released actual outlier payment data on a timely basis. The experience with this arrangement makes healthcare providers skeptical about equitable administration of any new, federally administered catastrophic program.

The outlier payment arrangement should be changed, regardless of new catastrophic coverage, to:

- o Make payments fully in accord with congressional direction;
- o Require regular reporting of actual payments for outlier cases;
- o Raise the ratio of cost paid for outlier cases; and
- o Remove the linkage between day and cost outliers.

Uncovered Services

Many other services of a catastrophic nature are also being provided to Medicare beneficiaries in the form of post-acute care, extended care, and noninpatient care for which Medicare coverage is unavailable or, in many cases, inadequate. Much of this service is uncompensated to the provider and no governmental program shares in these costs. In addition, services are provided to many people who are uninsured or underinsured due to unemployment, failure of employers to make adequate insurance available, and personal decisions to forgo or limit insurance coverage.

Medicare, as the largest payer of healthcare services, and other federal or state programs makes no contribution to the uncompensated portion of these services. The government is shifting its financial responsibility for these services to others. It is time for Medicare to meet its proportionate share of these costs.

Deductibles and Coinsurance

Deductible and coinsurance provisions make some of the payment for currently provided services the patient's responsibility. Medicare beneficiaries may insure this obligation with Medigap insurance, but this coverage would be replaced by the extended Medicare benefits envisioned under some catastrophic proposals being discussed. Patients who currently receive catastrophic services that Medicare or Medigap does not cover may pay out of their own pocket, but it is likely that many such cases are uncompensated and are added to providers' charity load.

The current deductible and coinsurance payments are not related to cost of service in any way. Thus, if payment for catastrophic service simply pays what patients might pay under the current deductible and coinsurance provisions, the providers will not get payments that are even remotely related to cost. If beneficiaries are required to pay a significant amount (Secretary Bowen's plan specifies \$2,000 a year) much of this will result in bad debts. While Medicare currently pays for bad debts, HHS Inspector General says this payment is inconsistent with prospective rates -- a fallacious argument as long as PPS rates are a roll forward of rates from an era when this payment was part of the formula. Deductible and coinsurance provisions must not add to the burden of uncompensated services.

UNCOMPENSATED SERVICES

A special HFMA task force has studied uncompensated services. It reached the indisputable conclusion that "if institutional healthcare providers are to remain financially viable, there is no alternative but for payers to pay for uncompensated services."* Providers cannot provide services if payment is inadequate. Thus, the responsibility for financing catastrophic services must not be shifted to healthcare providers.

Provision of uncompensated services is a real and legitimate business expense and all customers should share in this cost. Food given to the needy and credit losses incurred by a grocery store are an integral part of the prices paid by all customers of that grocery store. The same is true in any business. Similarly, Medicare must share in the financing of uncompensated services provided to non-Medicare patients.

*HFMA's statement concerning "Definition of and Payment for Uncompensated Services and Special Problems of a Disproportionate Share" is attached.
 The material has been retained in committee files, and is not reproduced here.--Ed.7

Recent legislation provides supplemental Medicare payments for the higher cost of serving Medicare patients by providers with a disproportionate share of uncompensated services. This provision does not address the uncompensated services problem, however. Congressional action to limit payments for outpatient services, even when the provision of such services is most cost effective, further exacerbates this problem.

The current procedure of indirect taxation through payment shortfall in Medicare and other government sponsored programs is not an appropriate model for meeting catastrophic illness requirements. It is essential to recognize that services that are provided must be paid for by someone and Medicare must pay its share.

INCREASED DEMAND

A government promise to cover the most difficult circumstances that require acute care services, to cover long-term care services, and to cover services to the uninsured or underinsured will doubtless foster provision of even more of these services than in the past. This is a desirable result for beneficiaries, of course, but a risk for both the government and providers. We only need recall the results of coverage of renal dialysis services to recognize that increases in demand and huge increases in cost will result. The ESRD program is clearly beneficial. Lives have been improved, extended, and saved. But the costs have been much greater than expected. If more catastrophic services are to be provided, the payment arrangements for these cases is a critical consideration. The government must recognize and be willing to accept the financial consequences of its public policy decisions. One of our chapter groups raised the pertinent caution that "the program will promise much and pay for little."

Diminished insurance coverage of patients' financial responsibilities, any change in arrangements for Medicare payment of bad debts, and the inadequate payments that result from the current "outlier" methodology all raise questions about the adequacy of payment for catastrophic services. These are concerns even at current levels of service and even more serious concerns if more catastrophic services are called for.

RULES CONCERNS

Providers also have no difficulty recalling the many ways that the government changes the payment rules after the game has begun. This happened repeatedly in the Medicare cost-based payment era and has continued with new creativity under PPS. The original goal of PPS was to limit the rate of increase in federal healthcare expenditures. Providers were offered the opportunity to profit through fulfilling that goal. The federal government has not only controlled expenditures, but has saved tremendous amounts in comparison to what would have been spent under the former system. But rigid budget targets resulted in changed rules and frozen rates; denying providers the promised rewards that were part of the original plan.

Revenue from new catastrophic insurance premiums could go a long way toward solving the federal deficit if the government devises ways to promise the services but avoid paying for them. The government will not, of course, simply receive and keep the revenue while telling the healthcare industry to provide increased services with no increase in payments. There are alternatives for changing the rules to achieve the same result, however. Current consideration of "rebasings" is an example. This is just a euphemism for lowering the rates hospitals are entitled to. Another option is for the government to freeze rates for current services, pay something for additional services, and say that total payments have increased.

The "case-mix shuffle" can also be used to avoid paying for expanded catastrophic coverage. (The government has reduced PPS rates to offset much of the effect of increases in case mix, the measure of the relative complexity of cases served. While everyone agrees that rates should not increase because of changes in case coding practices, the industry contends that cases served are really more complex and has challenged the government to do a study to measure the change in coding practices, but the government has refused.) As more catastrophic cases are served, the government can contend that the increased complexity apparent in higher case-mix amounts is just the result of a change in coding practices and deny higher payment for these more complex cases. Adding to this concern, some case weights have been decreased thereby lowering payment for comparable cases. The manipulation to payment by changing case mix is inappropriate.

Failure to recognize increased severity adds to our concern about the inequity of case-mix arrangements. Patients are being kept alive that would have died and costly new technologies are more broadly available. Thus the high cost of serving catastrophic cases is not adequately measured by the current case weight system changes in severity of illness must be recognized.

Payment rules must honor the original commitments, must not offset real case-mix change by rebasing and case-mix adjustments, and must recognize severity changes.

CONCLUSION

Attention to catastrophic illness issues is timely. We enthusiastically endorse more adequate federal financial participation in the catastrophic illness services that are now being provided. We support better access to catastrophic service for as many people as our nation's economy allows. We also support a financial relationship that is equitable and protects the interests of all people.

RRK/mlh
4/7/87

**Statement of
William S. Hoffman, Ph.D.
Director, Social Security Department
International Union, UAW**

Mr. Chairman, my name is William S. Hoffman. I am Director of the Social Security Department of the International Union, UAW. This statement is submitted on behalf of some 1.5 million active and retired members of the UAW and their families.

The UAW appreciates the opportunity to present our views on legislation to provide protection against catastrophic hospital and medical expenses under Medicare. We commend the Chairman and Members of this Subcommittee for addressing a most serious national problem: financial devastation of thousands of disabled and elderly Americans due to the expenses associated with a catastrophic illness, as well as the widespread fear and insecurity among Medicare beneficiaries that such financial devastation could come to them and their families.

The Need

The UAW supports enactment of legislation to provide Medicare beneficiaries with protection against catastrophic expenses; however, we have serious concerns about a number of the specific proposals which have been suggested.

The prospect of such legislation represents a healthy and positive response to the following problems:

- The proportion of disposable income which the elderly must spend for medical services has grown in recent years so that it is now greater than before the enactment of Medicare in the mid-1960s.
- In recent years there has been an abdication of responsibility by the Federal government in regard to the health care of older and disabled Americans, and a corresponding shift of their health care costs onto private sector third party payers, especially employers and labor unions, and onto the Medicare beneficiaries themselves. The proposed legislation would represent a reversal of this unfortunate trend.
- Protection under Medicare has been seriously eroded over the years as a result of cutbacks by the Federal government, plus incessant medical care inflation. For example, the Medicare Part A hospital deductible has risen from \$40 at the inception of the program to \$520 today.
- The private insurance industry has not been able to provide adequate Medicare supplementary coverage at an affordable cost to millions of Medicare beneficiaries. Some 30 percent of the elderly and disabled have no insurance coverage supplementary to Medicare. Even for those who can afford "Medigap" policies, their return in benefits is appallingly low — some 60 cents in real benefits for every dollar of premium, compared to a return of 98 cents on the dollar under Medicare. And Medicare does not have pre-existing condition clauses, which deny benefits to many senior citizens under private insurance policies.
- Millions of Medicare beneficiaries and their families are forced to live in fear that financial catastrophe will accompany serious illness or injury. It is unconscionable that so many older Americans must suffer from such insecurity and anxiety after a lifetime of hard work and sacrifice.

Proposed Measures

The Reagan Administration has taken a small, timid first step toward addressing these problems by endorsing the proposal put forward by Secretary Bowen. However, the \$2,000 "stop-loss" limit on Part A and Part B expenses under the Administration's proposal would only benefit the small number of Medicare beneficiaries who have an extended hospital stay. According to the Health Care Finance Administration, only 0.53 percent of the 30 million Medicare beneficiaries, fewer than 160,000 individuals, use coinsurance days (61 to 90 days of hospital care) or lifetime reserve days (60 non-renewable days for stays beyond 90 days) in a given year. Thus, the proposal would provide only about one in 200 Medicare enrollees with any significant help. Many thousands of other beneficiaries on limited incomes would be bankrupt before reaching the \$2,000 "stop-loss". In addition, since expenditures for prescription drugs, long term care, dental care and preventive health services are not counted toward this maximum, all Medicare beneficiaries would still face the threat of devastating catastrophic medical

expenses. While a small step in the right direction, the modest improvements proposed in the Administration's plan provide little basis for Medicare beneficiaries and their families to sleep more peacefully at night.

The UAW urges Congress to enact a package of improvements in Medicare which contains the following elements:

- Removal of the limits on coverage for extended hospital stays;
- Elimination or drastic reduction of the \$520 Part A deductible;
- Coverage of prescription drugs, especially maintenance drugs for chronic medical conditions, which alone can amount to annual costs of catastrophic proportions to many individuals;
- A much lower "stop-loss" than the \$2,000 figure in the Administration proposal; and,
- Extension of the days of coverage and reduction of copayment amounts under the skilled nursing facilities benefit.

The UAW also calls upon the Congress to begin to assess and address the problem of inadequate services for and financial protection against long term disabilities. Medicare does not now cover such services, contrary to the mistaken belief of many citizens. The Administration proposal does not include it. We know that these problems are difficult, complex and costly. They are not amenable to a quick fix. But they must be faced and will require strong public action. The UAW urges the Congress to begin a serious assessment and to map out a plan of action to address these crucial needs.

Additional legislation is also required to combat the problem of "balance billing" by physicians treating Medicare beneficiaries. Charges by doctors beyond fees allowable under Medicare would not count toward the "stop-loss" limits under proposals by the Administration and others. Such overcharges amount to a serious flaw in the shield of protection against high out-of-pocket expenses. Measures to mandate or seriously strengthen assignment by physicians under Medicare need to be enacted in order to prevent dilution of the intended protection.

Financing Issues

The issue of financing improvements in the Medicare program is of serious concern to the UAW, as it is for other labor and senior citizens' organizations and advocates for the disabled. The accumulated and prospective budget deficits, which represent one of the most enduring legacies of the Reagan Administration, greatly complicate the search for adequate and progressive financing. The UAW believes that sufficient revenues can be generated to pay for needed improvements in the Medicare program by taking a number of steps.

First, additional revenues can be realized by expanding Medicare coverage to include all employees of state and local governments. This is a long overdue step which would further the goal of making Medicare a truly universal program.

Second, additional savings can be achieved by recalculating the reimbursement rates for hospitals under the DRG reimbursement system. The recent study by the GAO suggests that the profit margins of many hospitals are sufficiently high to justify a "rebasng" of the DRG system.

Third, the UAW supports a premium-based financing system with a refundable income tax credit for low income beneficiaries, or some other provision to offset the cost to low income persons. We are willing to work with this Subcommittee on the specifics of such a proposal. The principal point is to protect lower income elderly Americans, who too often now cannot afford both food and heat, from the hardship represented by even a relatively modest increase in the Medicare Part B premium. As a result of Administration initiatives, there have been large increases in Medicare premiums in recent years; it is time to reverse this trend by changing the existing basis for premium-sharing in the Medicare Part B program. A return to the prior-law standard under which Medicare Part B premium increases were linked to cost-of-living

adjustments in Title II of the Act would provide substantial relief to all Medicare beneficiaries.

The UAW strongly opposes proposals to tax a portion of the actuarial value of Medicare benefits. This would establish an unfortunate precedent for taxing all health care benefits provided by employers to their workers and retirees. As you will recall, the UAW and other unions, as well as a broad segment of the business and insurance community, strenuously opposed such proposals when they were advanced by the Administration in the context of the tax reform legislation in the last Congress. We believe Congress made the right decision in rejecting such proposals at that time, and we see no reason to reverse that policy now.

Taxing Medicare benefits would also result in a substantial tax increase for a large portion of the elderly and younger disabled people and their families. The imposition of such a tax increase would be particularly unfair to those senior citizens and younger disabled workers who, in many cases, already receive protection against "catastrophic" medical expenses through insurance policies that are entirely paid for by their employer. This is the case for the vast majority of UAW retirees. The net result of such proposals to finance Medicare improvements by taxing the actuarial value of Medicare benefits would be to shift the cost of this protection from employers onto Medicare beneficiaries. We believe that this type of cost shift cannot be justified.

The UAW is concerned that the taxation of Medicare benefits would undermine support for the Medicare program. It is important to recognize the distinction between taxing cash income, such as Social Security benefits, and extracting taxes from individuals for in-kind services, such as health benefits, which only have some imputed actuarial value and do not represent any increase in cash income. In our judgment, there would be strong resistance among the elderly to the imposition of new taxes on Medicare benefits, since the beneficiaries are not receiving any cash income and may not even use the health care benefits in any given year.

The UAW also opposes any steps toward conversion of Medicare to a means-tested program. This does not mean that we would oppose certain forms of progressive financing, but maintenance of Medicare as a non-means tested element of our social insurance fabric is essential.

Finally, the UAW asks this Subcommittee and the Congress to recognize that millions of retired Americans, including the vast majority of UAW members, now have Medicare supplementary policies, paid for entirely by their former employers, which provide essentially the same or better protection as that which is proposed here today. The Administration plan, and other premium-based proposals, if not otherwise adjusted, would result in a windfall reduction in liability for many major corporations and a corresponding shift in cost, through the increased Part B premium, to Medicare beneficiaries. We trust that such an inequity could not be intended by the Congress. We urge inclusion of a "maintenance-of-effort" provision which would require employers to continue to contribute toward such coverage for a period of time, such as for the duration of existing collective bargaining agreements. We are prepared to work with this Subcommittee on the specifics of such a provision to avoid unfair cost shifting from employers to Medicare beneficiaries.

Summary and Conclusion

The UAW strongly supports enactment of improvements to Medicare to protect beneficiaries against catastrophic medical expenses. We urge this Subcommittee to develop a legislative package which includes the following elements:

- a more meaningful benefit package to provide real protection, including prescription drugs, unlimited hospital stays and a lower "stop-loss" limit;
- steps by Congress to address seriously the problem of meeting needs for long term care;
- further measures to end "balance billing" by physicians; and
- appropriate and equitable financing arrangements, including expansion of Medicare to cover all state and local government employees, rebasing of the DRG

reimbursement system for hospitals, a premium-related method coupled with some form of assistance for low income beneficiaries, and "maintenance-of-effort" provisions where catastrophic protection is now provided for retirees by their former employers.

Even the enactment of such a package would do nothing to provide health care protection for some 35 million Americans who currently lack any health care coverage, most of whom are employed workers. It would do nothing to provide protection against the cost of catastrophic illness for millions who are covered by inadequate insurance policies. These problems ultimately only will be resolved by the enactment of universal and comprehensive national health insurance.

The UAW would again like to thank this Subcommittee for the opportunity to present our views on this important subject. We are anxious to work with the Members of the Subcommittee in developing a package that will provide these much-needed improvements to the Medicare program.

Thank you.

NATIONAL ASSOCIATION of COUNTIES

440 First St. NW, Washington, DC 20001
202/393-6226

March 24, 1986

The Honorable Fortney H. (Pete) Stark, M.C.
C/O Joseph K. Dowley
Chief Counsel
Committee on Ways and Means
U. S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

Dear Mr. Stark:

The National Association of Counties (NACo) appreciates the opportunity you have extended us to submit written testimony for inclusion of the record of your March 30th hearing on catastrophic health insurance. This is an issue which our Association has identified as one of its priorities for the current legislative session. We welcome the prospect of working with you and your staff in the development of a sound legislative package over the course of the next several months.

America's county governments are vitally concerned about the continuing rise in health care costs and the inability of an estimated 37 million of our citizens to obtain adequate third party coverage to meet those costs. As health care providers of last resort for the poor in our communities, county governments are financially liable for filling in the gaps in the social safety net. When private resources are lacking and insurance, Medicare and Medicaid do not pay the bills, we do.

Indigent care is a major responsibility of county governments today. We spend in excess of \$25 billion each year to protect the health and safety of our constituents, and an increasing proportion of that investment is devoted to those who simply cannot meet their financial obligations for the health care services provided to them. Approximately 40% of the uncompensated care load in this country is borne by public hospitals.

Thus, to the extent that a national catastrophic health insurance plan is developed and implemented, to that extent some of the drain on the limited fiscal resources of counties will be relieved. If catastrophic insurance helps pick up the pieces for persons impoverished by medical calamity, counties will be freed to devote their health care resources elsewhere, strengthening budgets for prevention, health education immunization, nutrition and other programs which have been necessarily slighted because of the priority given to those who need care but cannot afford it.

NACo applauds the various proposals now before the Congress as important steps in the right direction. But our association believes that acute, episodic hospital-based catastrophic insurance does not go far enough toward meeting the broader constellation of populations at risk which merit consideration. The Bowen plan and its derivatives define an essential core of coverage, but it is estimated that only 3% of the elderly population will derive any benefit from an acute, episodic hospital-based approach.

County officials are concerned about a much larger population on uninsurables and individuals who may be compelled to "spend down" to poverty to cover their medical bills. The chronically mentally ill, AIDS victims, families with infants in neonatal intensive care, the disabled, and persons in long term care all face catastrophic health care costs which should be embraced in the design of a national plan.

At NACo's recent Legislative Conference, our Association adopted a resolution calling for comprehensive catastrophic insurance coverage. A copy is attached and we commend it to your attention. We believe that, even if fiscal constraints prevent you from broadening immediate coverage, implementing legislation should be staged to phase-in new populations at risk as part of a clearly defined agenda of reform. We recognize that there are significant costs to a comprehensive approach, but would assert that the current neglect and inaction have their price as well. Society is already paying for catastrophic health care costs in far less direct and desirable ways.

The National Association of Counties earnestly solicits your consideration of an expanded and comprehensive catastrophic health insurance package. We stand ready to support your efforts in that direction.

Sincerely,

John Horsley
John Horsley
President

Attachment

HEALTH & EDUCATION STEERING COMMITTEE

RESOLUTION ON

CATASTROPHIC INSURANCE

WHEREAS, The Congress is currently considering several alternatives to assist families and individuals who have incurred excessive health care costs of catastrophic proportions; and

WHEREAS, the Department of Health and Human Services estimates that at least 2.8 million Americans pay \$5,000 or more in out-of-pocket costs for health care, after insurance coverage, and that these individuals can be found in all age groups, race, and geographic regions of the country; and

WHEREAS, persons liable for catastrophic health care costs may be forced into poverty, spending their life savings and assets to repay medical bills; and

WHEREAS, those who should be the beneficiaries of the wonders of medicine and the compassionate hand of the healer too often become the victims of essential, life-maintaining services they cannot afford, creating stresses which fracture family stability and add to the social problems confronting society; and

WHEREAS, county governments are legally liable as the providers of last resort for those whose resources cannot match the expenses incurred by catastrophic illness and are compelled to seek relief through uncompensated charity care or county reimbursement; and

WHEREAS, county governments have both a humanitarian concern for the health and well-being of their constituents and a justifiable fear that local public resources may be unable to meet the rapidly increasing demand for financial support of catastrophic medical costs uncovered by traditional insurance and beyond the means of those impoverished by such costs;

THEREFORE BE IT RESOLVED, that the National Association of Counties strongly urges the Congress to enact a national catastrophic health insurance program which will limit out-of-pocket expenses for health care given by physicians and other health care providers, hospital services, and long term care; and

BE IT FURTHER RESOLVED, that a comprehensive, national catastrophic health care insurance plan recognize that the Federal Government must play an active and major role in the financing of such a plan, but that the private and state and local governments can contribute their fair share to the resolution of immense personal and social problems arising from catastrophic illnesses; that a true partnership must be forged between all levels of government, the private sector, and providers and employers to assure equitable relief for all persons who incur extraordinary health care costs; and

BE IT FURTHER RESOLVED, that a phased-in approach to a comprehensive national catastrophic health insurance plan may be necessary in lieu of immediate implementation of all segments, but legislation should clearly identify the staging of a phasing-in process of future expansion to a comprehensive level of coverage for all Americans.

Passed by Health & Education Steering Committee

March 15, 1987 (unanimous)

Statement of
the National Association of Manufacturers
on Expanding Medicare to Include Catastrophic Coverage
Before the Subcommittee on Health
House Ways and Means Committee
March 10, 1987

Mr. Chairman and members of the Health Subcommittee of the Ways and Means Committee, we are pleased to submit this statement on behalf of the National Association of Manufacturers. The NAM is an organization of over 13,500 corporations of every size and industrial classification located in every state. Members range in size from the very large to over 9,000 smaller manufacturing firms, each with an employee base of less than 500. The NAM is also affiliated with the National Industry Council which includes 135 state and local business associations representing 138,000 individual companies.

Summary

NAM supports selected expansion of Medicare to provide catastrophic protection to Medicare beneficiaries for services presently covered by Medicare subject to the following provisions. Such initiatives must recognize rapidly rising health care inflation, a growing elderly population demanding increased resources, a relatively diminished pool of workers to support Medicare participants in the future, and large federal budget deficits. Program financing must be adequate to insure that costs not be increased and government fiscal responsibility is not shifted to employers; scope of coverage is limited while the private insurance market is encouraged to continue providing supplemental protection; and the program design must adhere to strict cost containment principles. Government through tax incentives should encourage the employer role in providing post-employment health insurance. NAM strongly opposes any attempts to make employer plans primary for retired Medicare participants.

The Medicare Program: Public-Private Sector Cooperation

From its inception in 1965, Medicare was designed as a cooperative effort between the federal government, private employers and American workers. A payroll tax of 1.45 percent (levied on a wage base of \$43,800 in 1987) is paid by individual employers and their employees to finance hospital services, skilled nursing care and home health. (Part A).

For fiscal year 1988, the Administration has budgeted \$81.9 billion which assumes enactment of certain legislative and regulatory changes. This figure represents a 4.8 percent increase over 1987 expenditures. Without these proposed changes, Medicare would grow 10.8 percent over 1987.

Part B (physician services) of Medicare is financed through a beneficiary paid premium covering 25 percent of program costs with general revenues making up the rest. Initially, the premium was intended to finance 50 percent of program costs, but, rapidly growing health care inflation quickly convinced lawmakers to enlarge the federal commitment.

Rapidly growing health care costs also spurred major payment reform in Part A in 1983 when the hospital prospective payment system replaced a cost-based system. Other cost control efforts included indexing the annual deductible for hospital care to medical inflation.

NAM strongly supports these cost management efforts to maintain the long term financial integrity of Medicare. It is important to recognize that the Medicare Trust Funds, while financially solvent at present, face an uncertain future. According to the 1986 report of the Medicare Board of Trustees, Medicare's hospital insurance trust fund is barely sufficient to ensure the payment of benefits and maintain the fund at a level of one-half year's disbursements over the next seven to nine years under moderate economic assumptions, and the fund will be completely exhausted in 1993 under less optimistic assumptions.

It is clear that the federal government is in no position to assume increased costs involving an expansion of Medicare services, nor should employers be expected to assume increased responsibilities when they are already struggling to maintain their position in global markets.

Inappropriate shifts of responsibility sometimes produce unintended consequences. An amendment to the Age Discrimination Act in 1982 required companies with 20 or more employees to continue to provide health insurance to workers 65 to 69. Employers were made the primary payer of health care benefits for this category of workers. Previous to passage of the amendment, firms with 100 employees or more had employed three-fourths of workers aged 65 to 69. This figure declined to two-thirds, a year later.

Further shifting of federal costs to the private sector should be avoided. Government should continue to be the primary payer of health care benefits for retired persons age 65 and over.

The Private Sector and Post-Employment Health Benefits

In addition to sharing support for Medicare through payroll taxes and general revenues, the private sector has assumed substantial responsibility for providing health benefits to their retirees. Today 84 percent of employees of large firms and nearly half of those working for firms with 100-250 employees participate in health plans that continue health coverage after retirement. Currently, nearly seven million retired Americans and their dependents are covered by these health benefits.

Generally, corporate plans provide coverage to retirees and their families until age 65. After that age the plan is adjusted to recognize what Medicare provides. Often employers pay the Medicare Part B premium for their retirees. Many provide benefits to supplement Medicare (e.g., paying deductible or benefits after Medicare is exhausted).

The federal government has not offered much incentive for the private sector to provide post-employment health benefits. For example, the Deficit Reduction Act in 1982 severely limited the ability of employers to prefund post-employment health insurance for retirees. Prior to that time, certain tax incentives were available. For the private sector to continue its commitment to retirees, incentives such as those lost through DEFRA, should be restored. Such measures will assure continuation of private-public sector cooperation in providing health insurance protection for this group and avoid costly government expansion in this area.

Medicare and Catastrophic Medical Expenses

The prognosis for catastrophic medical expenses for the elderly is not good. Americans 65 and older will more than double between 1980 and 2040, and those 85 and older who are at greatest risk for chronic illness will increase an expected 20 percent over their numbers today. The need for sophisticated medical technologies, prescription drugs and similar items and services will grow while more people dependent on Medicare will severely strain the system.

Thus, it is timely to begin consideration of alternatives to provide protection for catastrophic medical expenses for the Medicare population. It is also obvious that cost constraints must underlie the program design which should be confined to Medicare covered services only. While the need for long term nonacute custodial care is significant, federal commitments should not at this time, use limited resources for this purpose at the expense of providing basic acute care protection. Coverage of other nonacute care services should be maintained through the private insurance system. Commercial insurers and Blue Cross/Blue Shield should continue to improve their products to serve the market they are best suited to handle and limit further expansion of government entitlement programs.

Catastrophic Insurance Proposals

There is growing consensus for passage of catastrophic health insurance for Medicare beneficiaries. This discussion should recognize that resources are limited to provide currently promised benefits, while health care inflation continues its rapid increase--10.7% of GNP or a 8.9 percent increase over the previous year. Thus, it is essential to narrowly define any new program expansion.

The two major proposals--Bowen and Stark-Gradison--now under Congressional consideration, have wisely limited the scope of benefits to acute care services. NAM believes both approaches deserve careful study. Underlying this discussion is the need to make an accurate assessment of expected program costs. The federal government has a poor record for doing so. As early as 1967, the Medicare Board of Trustees reported that the Medicare program was some 0.28 percent of payroll tax higher than the official estimates of 1965 and recommended a payroll tax increase or the fund would be deleted by 1971.

Below, we offer a few comments on the differing approaches to financing catastrophic insurance and urge that Congress carefully study the political, financial and social ramifications in making this important decision.

Premium Financing. The Reagan-Bowen plan would add an indexed premium of \$4.92 per month to Medicare Part B. For the added premium, enrollees would receive unlimited hospital and physician care after a \$2,000 out-of-pocket limit had been reached. This approach maintains the insurance concept of Medicare by encouraging risk sharing across the broadest possible base. The premium approach, to its advantage, also serves to focus attention on cost.

Because the premium and the out-of-pocket amount would both be indexed for inflation, there is some danger that Congress may find it politically difficult to accept scheduled increases.

Recently, when the Medicare deductible was scheduled to rise to \$572 in 1987, Congress was quick to lower that amount to \$520 and limit future increases. Estimates from the Congressional Budget Office on the Bowen plan recommend a premium of \$6.40 for 1988. Thus, political courage may be needed sooner than expected.

Some elderly persons may not be financially able to pay \$4.92 per month. For them, fees based on a sliding scale according to income, arrangements through Medicaid, or similar approaches should be explored.

Tax-Based Financing. Representatives Stark (D-CA), Gradison (R-OH), Rostenkowski (D-IL), and Duncan (R-TN) have proposed taxing 50 percent of the actuarial value of Part A and 75 percent of part B. Medicare's benefit package is currently valued at \$1,800.

Taxation of benefits would avoid the use of general revenues should premiums prove inadequate. Congress could also avoid the painful decision of raising premiums to meet increased program costs. The equity question of lower income beneficiaries would be addressed since approximately 65 percent of elderly taxpayers would pay no tax.

It is important to note the Congress only recently made major changes to the tax code and re-opening the process could damage those changes before they are given a fair trial. Taxation also implies means testing. If the program is to be significantly altered in this direction, its impact must be more openly and fully explored.

A benefits tax raises other points, also. All Medicare enrollees of Part A (a nonvoluntary program) whether or not they elected to take Part B, would be taxed. Because this is a less visible payment method, there may be a temptation to increase program funding since financing will be less obvious to the public.

Of perhaps greatest concern is the dangerous precedent set by taxing Medicare benefits and its relationship to all health benefits. Historically, employment-based health insurance has enjoyed tax-preferred status for many reasons. Government, workers, and their employers have recognized the value of health insurance in insuring physical and emotional well-being. Eliminating tax preferences may persuade some persons to forego benefits rather than pay the tax. As such, taxation could undermine an important source of protection for 135 million Americans.

Summary and Conclusions

NAM supports selected expansion of Medicare to provide catastrophic protection to Medicare beneficiaries for services presently covered by Medicare. Such initiatives must recognize rapidly rising health care inflation, a growing elderly population demanding increased resources, a relatively diminished pool of workers to support Medicare participants in the future, and large federal budget deficits. Program financing must be adequate to insure that costs not increase, government fiscal responsibility is not shifted to employers; scope of coverage is limited while the private insurance market is encouraged to continue providing supplemental protection; and the program design must adhere to strict cost containment principles. NAM strongly opposes any attempts to make employer plans primary for retired Medicare participants.

NAM is pleased to work with the Subcommittee in developing a workable catastrophic health insurance program for Medicare beneficiaries. A major part of this effort is recognizing the important role played by employer-sponsored insurance for retirees and a continued need to provide incentives for doing so.

STATEMENT

Submitted By

National Association of Rehabilitation Facilities
American Academy of Physical Medicine and Rehabilitation
American Congress of Rehabilitation Medicine
National Head Injury Foundation
National Easter Seal Society

to the
Subcommittee on Health
House Committee on Ways and Means

for the record of

the Hearings on Catastrophic Health Coverage
March 4 & 10, 1987

Mr. Chairman:

This statement is submitted by the National Association of Rehabilitation Facilities (NARF), the American Academy of Physical Medicine and Rehabilitation, the American Congress of Rehabilitation Medicine, the National Head Injury Foundation, and the National Easter Seal Society. NARF is the principal national membership organization of facilities rendering medical and vocational rehabilitation services. The membership includes almost all freestanding rehabilitation hospitals in the country, a large number of rehabilitation units of general hospitals, outpatient rehabilitation facilities, and vocationally-oriented agencies. Medical rehabilitation facilities deal with the mitigation and remediation of physical and mental disabilities caused by disease and trauma and help people become independent. Vocational programs assist people with such disabilities to go back to work. Most, if not all, of NARF's medical membership participate in the Medicare and the Medicaid programs.

The American Academy of Physical Medicine and Rehabilitation is composed of about 3,000 certified physicians and residents who practice physical medicine and rehabilitation, known as physiatrists. The American Congress of Rehabilitation Medicine is a professional association of about 3,000 rehabilitation specialists, and includes administrators, practitioners, and physicians interested in rehabilitation medicine who are not physiatrists and others. The professionals of these associations provide most of their services to patients people with severe disabilities and the chronic illnesses.

The National Head Injury Foundation is a membership organization of persons who have experienced traumatic brain injuries, their families and providers of services. The purpose of the organization is to encourage the development and provision of services to victims of head trauma and the prevention of this type of injury.

The National Easter Seal Society represents more than 200 state and local societies that collectively serve over 1 million people annually. Easter Seals provides a wide range of community-based rehabilitation services including outpatient medical services, vocational rehabilitation, special education, recreation and related services. A substantial share of these services are provided to Federal program participants, including Medicare and Medicaid beneficiaries.

Medical rehabilitation facilities are uniquely pertinent to the needs of the Medicare population, providing a substantial portion of their services to patients experiencing problems associated with age such as stroke, arthritis and hip fractures. Approximately half the patients served by rehabilitation hospitals and units are Medicare beneficiaries.

Rehabilitation facilities have a unique perspective on the issues before this Committee. They chronically are faced with inadequacies in public and private insurance coverage for their services and for subsequent placement of patients who have completed a regime of services in rehabilitation hospitals and units.

Scope of Statement.

This statement is addressed to the various proposals pending before the Subcommittee dealing with coverage of catastrophic health care costs. The subcommittee has received testimony from a variety of witnesses regarding the financing of catastrophic coverage and the need for such coverage. These organizations will not duplicate these analyses, but rather focus on those points where its particular expertise may be most helpful -- the special relationship between catastrophic health problems and rehabilitation.

Purpose of Rehabilitation.

The purpose and goal of rehabilitation is to restore patients to the maximum level of function. This includes restoration of walking, and all activities of daily living. A corollary objective is the mitigation or elimination of dependency. In the context of the issues before this committee, rehabilitation is certainly an element of the "catastrophic" costs of health care. It is also a means of reducing such costs, since provision of timely and effective rehabilitation services to a person who has experienced disease or trauma can greatly reduce that person's subsequent dependence and need for acute and/or long-term care. In developing a catastrophic health care bill, this subcommittee should address not only issues of coverage and financing, but also the role of rehabilitation in reducing the need for such services.

Coverage.

The Administration's bill and others pending before the Subcommittee would expand Medicare benefits for the currently covered population to limit the financial impact of the costs of acute medical services on Medicare beneficiaries. Enactment of this legislation would be beneficial to Medicare patients and providers of rehabilitation services by limiting the financial exposure of such patients. We support this objective, but wish to note some of the things the Administration's proposal and most other bills would not do.

First, they would not provide coverage for the catastrophic costs of long-term care for the Medicare population.

Second, they would not provide coverage for the catastrophic costs of care for the uninsured and/or underinsured segments of the population not covered by Medicare. There are over 35 million people in this country who are uninsured or underinsured. Members of this group which experience traumatic injury are often young. Many suffer residual deficits of monumental proportions from brain injuries, damaged spinal cords and similar catastrophic conditions.

Third, these bills would not deal with the gaps in coverage in the Medicare program, including policies of the Health Care

Financing Administration and its intermediaries and carriers, which limit the ability of Medicare patients to receive needed rehabilitation services.

We suggest that each of these areas deserves the attention of this Subcommittee in a catastrophic health bill or by other legislative means.

Need for Long Term Care.

As the population ages, there will be more elderly people who need varying levels of support to live with dignity. As medical science continues to improve its lifesaving techniques, there will be more people who survive trauma but are left with severe disabilities. Collectively these groups, while a relatively small portion of the U.S. population, account for a high percentage of health care expenditures. Few have coverage for the services they require and the effect on them, their families and providers of care who serve them is "catastrophic." The long-term care issue is not immediately before you and this statement will not dwell on it, except to urge that any long-term care legislation that may be developed focus on two points: first, the needs of young people disabled by disease and trauma; and, second, the need for rehabilitation services and community-based support services to reduce the number of people consigned to institutional care, primarily nursing homes.

Need for Catastrophic Coverage for Other Than Medicare Population.

On point one, the need for coverage of populations other than the elderly, there are things that can be done in the present legislation.

Consider one group that illustrates this issue -- victims of traumatic brain injuries. There are perhaps 900,000 incidents of brain injury in the country each year. About 10% of these are severe. Most such injuries occur among young people who engage in risk-prone activities. Over 50% are the result of motor vehicle accidents. Many are not insured or are underinsured. Patients are uninsured because they are too old to be covered by a parent's health care insurance and have not obtained insurance on their own. They are uninsured because few health insurance policies cover the scope and duration of services required by these patients. These cases involve coma management, intensive care and extensive rehabilitation services, both inpatient and outpatient.

The costs of care for this population are staggering. The National Head Injury Foundation estimates that on the average a patient with a serious traumatic brain injury will spend 60 to 90 days in intensive/acute care at a total cost of between \$120,000 and \$180,000. Such a patient will then require 90 to 120 days in a very intense rehabilitation program at a cost of \$60,000 to \$70,000 and perhaps 15 months in an extended rehabilitation program at an additional cost of \$200,000. In serious cases, residual functional deficits require life-long support services with a cost of \$60,000 to \$100,000 per year.

Costs of this magnitude, not to mention the emotional stress for patients and their families, are "catastrophic" by any standard.

The experience of patients with spinal cord injuries is similar.

These populations experience catastrophic events that often exceed those of the patients generally covered by Medicare, both

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in cost and duration. The tragedy of severe disability and dependence is equally painful for both the old and the young. It is, however, of potentially longer duration for the latter and in their cases strikes people who have had no opportunity to accumulate assets or retirement benefits.

Currently, coverage of this population is hit or miss. Last year The Washington Post carried a four-part series on the experience of a 20-year-old Virginia man and his family after he received severe head injuries in an automobile accident. The articles traced his course from a shock/trauma center through rehabilitation. This excellent series highlighted all the emotional and financial stress which a family experiences when a member suffers a catastrophic illness. A reprint of this series is attached. It is a case-study worthy of your attention.

The series highlighted the problems the family faced when the young man was ready for rehabilitation, after 78 days in acute care. When the family sought to have him moved to a rehabilitation unit in a local hospital (which is a NARF member), they discovered that their health insurance carrier, a health maintenance organization (HMO), Kaiser Permanente, refused to cover the required rehabilitation services. The family was enrolled with Kaiser by virtue of the father's being a federal employee.

In this case the shock/trauma charges alone were over \$100,000. The family had never worried about bills before, assuming that its medical insurance covered all possibilities. The family, like many others, had no reason to believe that they would find themselves without coverage. Once their son began to emerge from a coma and qualified for a rehabilitation center, Kaiser Permanente first stated it would pay none of the cost, estimated at \$18,000 per month, for rehabilitation at a rehabilitation center near their home. The family, upon reviewing the benefit booklet which had been supplied, found at the very end of the list of exclusions under "What Is Not Covered" an exclusion for "the services of a rehabilitation center." These types of exclusions are not uncommon in commercial insurance coverage and are particularly common with HMOs. The HMO would cover 100 days a year, but only if the son were placed in a nursing home, for essentially custodial care. The family's only other option was to qualify for Medicaid, but the only state approved Medicaid facility was 100 miles away in Richmond.

After repeated meetings with the family, the HMO agreed to pay for four more weeks of care in a general hospital while the son received speech and physical therapy. It still would not pay for rehabilitation once the son left the hospital. Eventually it covered only 60 days of rehabilitation care in the rehabilitation unit of the local hospital.

Kaiser Permanente stated that it tries to predict how many catastrophic bills it may incur and, while it may be willing to absorb "our fair share of cases like this," it did not want to price its product out of the market and suggested that families obtain major medical policies for an additional monthly premium. The Post noted that major medical policies can be difficult to obtain and that Kaiser and most HMOs simply do not offer them.

The rehabilitation unit treating the man was finally qualified by the state to treat Medicaid recipients.

This experience is typical. It illustrates the need for some sort of catastrophic coverage of this segment of our population.

We suggest that it is both prudent and humane to address the needs of the non-elderly who experience catastrophic circumstances and the pending legislation is a good place to do it. Currently, persons who have sufficient work experience under Social Security and who become disabled will ultimately become eligible for Medicare, but only after a two-year waiting period. To this two years can be added the period from the onset of disability to the date a determination of disability is made by the Social Security Administration, usually at least five months. This long delay in provision of health care benefits means that such Medicare coverage has no bearing on the rehabilitation of the person in question. This policy has the perverse effect of providing no assistance to avoid dependence and then making health care benefits available when the optimum time for rehabilitation is past.

The simple solution to this anomaly is to eliminate the two-year waiting period for Medicare following a determination of disability, as proposed in H.R. 643 introduced by Congressman Frank.

Elimination of the two-year waiting period for Medicare would be a significant contribution to the coverage of catastrophic health care costs for patients with disabilities, particularly when coupled with the supplemental program envisioned in this legislation. Medicare is now "second-pay" to other health care coverage so that elimination of the two-year waiting period would not substitute Medicare coverage for any commercial coverage that a patient may have.

Valuable as elimination of the two-year waiting period would be, it would not address the needs of patients who do not have sufficient work experience to qualify for Social Security. For these people the only potential alternative coverage, in the absence of preexisting commercial insurance, is Medicaid. Medicaid programs vary widely in the coverage provided for rehabilitation. For those with catastrophic trauma Medicaid may be available, but often it is limited by restrictions on eligibility or coverage. With regard to the former, many patients with catastrophic trauma are not eligible for Medicaid at the time of their injury. They become so by "spending down" to the levels required by state programs.

In this regard there is a need for legislation to eliminate the requirement for spousal or familial impoverishment to permit a person with catastrophic disability to qualify for care under a state Medicaid program. There are a number of legislative proposals pending in this area, including the Medicaid Spousal Protection Act of 1987 sponsored by Senator Mitchell. We suggest the inclusion of this concept in a catastrophic bill to permit a person to qualify for Medicaid without requiring destitution on the part of his or her spouse or family.

We suggest that a catastrophic health bill should address this population by amending Title XIX of the Social Security Act to make persons suffering catastrophic medical expenses a mandatorily covered group under Section 1902(a)(10)(A). Further, the mandatory services specified in Section 1905 (and incorporated by reference in Section 1902) should be amended to provide for a cap of the type now contemplated for the Medicare program. By these changes, state Medicaid programs would be required, as a condition of federal participation, to provide coverage of catastrophic care. We suggest that the financial standards adopted for the Medicare program be used for this purpose.

Medicaid programs are second pay to other coverages and would become payors of last resort in cases where all other coverage, including Medicare, is not available or is exhausted.

Finally, taking a lesson from the case discussed above, the federal government should put its own house in order by providing catastrophic coverage through group health insurance programs which it sponsors for its employees. We understand such an effort is underway. This can be achieved by establishing minimum standards for such policies that include both the coverage of rehabilitation services and a cap on out-of-pocket expenditures as now proposed for Medicare beneficiaries.

Prevention.

While it is perhaps beyond the scope of this Subcommittee's jurisdiction, the organizations which submit this statement wish to note that there are steps which can be taken by the Congress to prevent certain catastrophic injuries. As we struggle with the question of provision and payment of medical services to people with catastrophic injuries, we certainly should address the prevention of such injuries.

We live in a risk-prone society where speed, alcohol and the failure to deal with both responsibly lead to many catastrophic injuries.

The fact that catastrophic health care costs are viewed as a national problem is indicative of the fact that the societal cost of catastrophic care is beyond the capacity of states. We suggest that national solutions are warranted. The federally mandated 55 mile an hour speed limit provides a prototype. Using federal highway funds as both the carrot and the stick, states should be required to have mandatory seat belt laws, mandatory helmet laws for both bicycles and motorcycles and requirements that all motor vehicle operators have insurance coverage adequate to cover catastrophic costs associated with severe injuries such as traumatic brain and spinal cord injuries.

If the federal government is going to be the ultimate insurer of many of these injuries, it is certainly logical for the Congress to aim at the causes of many of these injuries.

Need for Elimination of Medicare Restrictions That Inhibit Rehabilitation.

We also urge the Subcommittee to recognize that current practices of HCFA deny certain rehabilitation services to Medicare beneficiaries by excluding them from coverage. Adoption of the scheme of catastrophic benefits envisioned in this legislation will not solve this problem, simply because the services will not come within the definition of services to which the financial cap applies. We submit to you that limitations which deny needed rehabilitation services have the effect of increasing dependency and thereby ultimately increasing acute care. Specifically, the refusal of HCFA to permit off-site delivery of services by comprehensive outpatient rehabilitation facilities, while rehabilitation agencies and hospitals may provide such services, makes no sense.

Additionally, HCFA has been establishing screens for the delivery of certain rehabilitation services, including physician services, which act as caps on such services and are often unrealistic. Medicare carriers require additional documentation of medical necessity, but do not tell physicians what that documentation is to include. The same is true for other

services, such as physical therapy. As a result, beneficiaries are being denied access to and provision of needed and covered services.

Summary.

In summary, we suggest that in fashioning a catastrophic healthcare bill this Subcommittee broaden the concept of the Administration's bill, which is concerned only with those elements of the population who have no protection against such costs.

Specifically we suggest the following:

1. Eliminate the two-year waiting period for initiation of Medicare coverage following a determination of disability for purposes of Social Security Disability Insurance benefits.

2. Mandate the coverage of catastrophic health care costs, including the costs of rehabilitation, in federally-sponsored group health programs.

3. Require coverage of catastrophic health care costs (as a matter of coverage) and persons experiencing them (as a matter of eligibility) in state Medicaid programs.

4. Remove the offsite restriction on delivery of CORF services included in the current regulations. This restriction is not required by law.

5. If HCFA and its Part B carriers establish screens on physician and other services, HCFA should be required to work with professional groups in developing such screens and outlining the required documentation. Any such requirements should be subject to publication in the Federal Register in proposed form with a minimum 60-day comment period.

Conclusion.

NARF, the Congress, the Academy, the NHIF and Easter Seals strongly support the enactment of a comprehensive health care bill. They believe it should include elements of the population bypassed by the Administration's proposal and that comprehensive rehabilitation services, which are required by a large percentage of persons experiencing catastrophic incidents, should be clearly covered.

These organizations will be pleased to provide more detailed proposals on the points discussed above at the request of the Subcommittee.

This Statement submitted by:

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STATEMENT OF
FORMER CONGRESSMAN JAMES ROOSEVELT
CHAIRMAN OF THE NATIONAL COMMITTEE
TO PRESERVE SOCIAL SECURITY AND MEDICARE

I am James Roosevelt, Chairman of the National Committee to Preserve Social Security and Medicare. In that capacity, I represent more than four million members, for most of whom Medicare is the primary health insurance protection. For far too many of them, those with low income and little or no other resources, Medicare is their only health insurance coverage. I commend you, Mr. Chairman, for holding these hearings and your initiative in proposing legislation to search for solutions to overcome the financial tragedy that a catastrophic illness can cause for too many older Americans. Your leadership on this issue is deeply appreciated.

It is not an exaggeration to say that Medicare has made the difference between life and death for countless thousands of seniors who might otherwise have delayed seeking care until a once treatable condition had become life-threatening. As vital as it is, however, Medicare does not cover a full range of medically necessary services. Sadly, thousands of individuals and families are reduced to poverty when illness strikes. To be forced into bankruptcy because of unmanageable health care costs is a true catastrophe. Protection against such catastrophic expenses is Medicare's unfinished business.

Mr. Chairman, as you know, this Congress is about to make a very important decision. Will Congress decide to tinker with the current Medicare system or will Congress take the bold step of comprehensive reform and expand Medicare to cover long-term care and prescription drugs? The President proposes a very limited expansion of Medicare to protect seniors against catastrophic hospital and doctor costs. Legislation introduced by you and your colleague, Mr. Gradison, while far better than the President's proposal, still does not go far enough. At least one bill, introduced by Representative Claude Pepper (H.R. 65), however, includes catastrophic coverage for long-term care and prescription drugs as well as preventive exams and vision, dental and hearing care. Senator Sasser has introduced a similar bill, S. 454, in the Senate but without coverage for prescription drugs.

Assuring quality health care to all citizens who require nursing home care or extended home care or who depend on drug therapy certainly represents an important financial commitment. The National Committee fully appreciates the challenge you face. Yet we agree with Representative Pepper when he says that we cannot afford NOT to cover long-term catastrophic health care costs. This may well be the historic time to search our conscience and our coffers to come up with a solution.

A LIMITED PROPOSAL

President Reagan's proposal falls short of providing true catastrophic Medicare protection. Medicare beneficiaries face the catastrophe of bankruptcy because Medicare pays for less than half of the health care of seniors. Under the President's proposal, Medicare would pay for Medicare covered hospital and doctor expenses above \$2,000. However, most people will already have spent a lot more for uncovered expenses such as nonassigned doctor fees or prescription drugs. Many individuals suffering from chronic illnesses, such as Alzheimer's disease or arthritis, do not need doctor and hospital care. They are more likely to incur catastrophic expenses related to nursing home care, home health care and/or prescription drug expenses. The President's proposal would not help these victims.

Among the thousands of letters received each week by the National Committee to Preserve Social Security and Medicare are numerous pleas for help with health care costs. Some have unpaid medical bills which often total more than two or three years' income. Many individuals and families are confronted with total impoverishment when bills for acute or chronic care reach catastrophic proportions. It is no wonder that many seniors and their families are concerned for the future.

I recently received a letter from a National Committee member from Knoxville, Tennessee. This women's story is a tragic reflection of the inadequacy of Medicare's current coverage:

I am writing to tell you about my husband. Henry has been in the hospital for 23 days. My son had to put him in a nursing home today... He has been bad for over a year. He has had two strokes. I have waited on him and me sick. See, I live by a pacemaker and can hardly walk because of arthritis. The doctor said I could no longer care for him because I couldn't lift him or give a bath or give him IVs so he had to go to a nursing home... We are both 74 years old and I feel God has been good to us both. He worked until he was 70 years and paid in Social Security ever since 1937. He sure wasn't lazy.... All of our life savings are gone now. Henry and I together got \$831 Social Security. They (the nursing home) will take \$562 of his and that will leave me \$269 to live on, which sure will be rough going, me with this sickness I have. My medicine really costs (\$80 a month). I'm going to try to get SSI and Medicaid, food stamps. My pacemaker check on the phone is \$30 a month.

President Reagan's legislation would not help this couple pay for his care in the nursing home or for her prescription drugs. She might have been able to keep her husband at home if she had some physical assistance. After a lifetime of work and saving, this woman will now be permanently dependent on public assistance. In fact, the President proposes to help only 800,000 seniors a year or about 3 percent. It will more likely upset the other 97 percent to pay \$60 a year more in premiums yet receive no additional benefit. Clearly, it is politically dangerous to offer such a limited proposal. Seniors expect greater vision and more tangible results.

COMPREHENSIVE CATASTROPHIC MEDICARE COVERAGE

At the beginning of this century, the most prevalent health problems of seniors were acute. Today, the most prevalent health problems are chronic, and the likelihood of having a chronic or disabling condition increases dramatically with age. An estimated 85 percent of Americans are underinsured against the catastrophe of long-term care. While there is little coverage for home care and prescription drugs, nursing home care coverage is almost non-existent. H.R. 65 would cover a full range of long-term care services including nursing home care, community-based care and prescription drugs.

Nursing home care. Probably the greatest fear held by older persons is to become so totally disabled that they must enter a nursing home for an extended period of time. Although only about five percent of the elderly live in nursing homes at any given time, about 20 percent of the very old are institutionalized. The fear of having to live a dependent life in an institutional setting is coupled with the enormity of the expense and drain on resources. The average person will deplete his or her resources in little more than three months at the rate of about \$22,000 a year for nursing home care.

The misconception that Medicare covers nursing home care is still all too prevalent. Yet Medicare covers only two percent and private insurance just one percent of this nation's nursing home bill. While many older Americans are under the illusion that they are protected by Medicare and Medigap insurance, the devastating reality is that only after spending themselves into poverty does the public step in to help. Medicaid covers nursing home care for impoverished patients - the last resort for many families who must suffer the humility of seeing their dependents supported by a welfare program.

Community-based care. Since the beginning of Medicare and Medicaid, public policy has been more directed to support of institutional care than community-based care. As important as is coverage of nursing home stays, it is equally important that any new catastrophic legislation not be biased toward institutional care. For every one frail person in an institution there are two equally frail people being cared for in the community. In addition to the very frail, many more seniors require some type of assistance with activities of daily living. Most are cared for informally by families, others by a combination of informal and formal support services. New policy should encourage community-based care by increasing support to families caring for their dependents.

For seniors themselves, home care has always been the preferred care, whenever possible. Families respond to this preference by performing 80 to 90 percent of the care given their dependent relatives. Still, there is a great need for formal home care services to complement family care. Our nation has a serious problem with home care. Medicare covers only limited, acute skilled nursing care, while coverage for homemaker and chore services is virtually non-existent.

The demand for home care has increased by 37 percent since the Medicare Prospective Payment System for hospitals was implemented in 1983. Yet Medicare is increasingly denying coverage for home health services. The General Accounting Office recently found that 86 percent of hospital discharge planners reported problems with home health care placements. Under an expanded health care system, home care should be made available through a comprehensive needs assessment and a care management system.

Adult day care is another important element in the continuum of care necessary to meet the growing need of aging members of our society. Only within the last decade has this type of custodial care gained acceptance. We currently have an estimated 1,000 adult day care centers in the United States providing service to between 10,000 and 15,000 disabled adults.

A recent study by the National Council on the Aging found the average participant of an adult day care center to be a 73 year old female living on a \$478 a month income. She is living with family or friends. Half of the participants need supervision, one out of five have difficulty walking, and about one out of eight is wheelchair-bound. The average charge per day is \$22. The indication is that adult day care participants are mentally or physically frail. While the participant receives both care and socialization, the family members receive respite from the stresses of providing care to a frail person. Adult day care can provide a place to bring the dependent family member from a few hours a week to enough hours to enable the caregiver to work in a job outside the home. With this type of support, the family is able to provide care longer and, therefore, postpone or prevent institutionalization.

Prescription drugs. Another example of the inadequacy of Medicare's coverage is the failure to pay for prescription drugs. For some older people, chronic, long-term care consists of taking the appropriate prescription drug. However, these prescriptions can be very expensive. It is not unusual for a person with a heart condition to spend more than \$100 per month on medications needed to sustain life. Diabetes is another example of a chronic health problem which requires careful monitoring and access to insulin. If a diabetic cannot afford insulin, Medicare may eventually have to pay to amputate his or her leg. This individual may also end up in need of nursing home care -- thousands of dollars spent because a few pennies were "saved."

The heaviest use of prescription drugs is, understandably, among the older population. Older Americans are 2 1/2 times more likely to be taking three or more prescription drugs regularly than younger adults. Most seniors, an estimated two-thirds, take at least one prescription drug at any one time, and many take as many as four or five drugs a day. Unfortunately, Medicare covers only drugs used while the person is hospitalized or in a skilled nursing facility. Medicaid will only cover the costs of prescription drugs for the poor. Payments for drugs represent 20 percent of senior citizens' total out-of-pocket health care costs and average \$340 per person per year.

FINANCING

Despite the desire of policy makers to protect Americans from the cost of a catastrophic illness, Representative Pepper is one of the few to have made a proposal on a scale sufficient to solve the problem. In an era of large government deficits, most worry that the American people would not support a new, costly government commitment. But this argument ignores the fact that the American people already pay for catastrophic illness.

Seniors and their families pay almost as much of their health care bill as Medicare, but only about one quarter through insurance premiums. The majority of private expense is in the form of Medicare copayments and uncovered expenses. Medicaid and other government programs pay for about 10 percent, mostly for nursing home care. If Medicare paid for catastrophic illness for seniors, Medicaid's resources devoted to senior citizens could be shifted to Medicare. Most seniors and their families could afford to contribute more to Medicare through premiums and taxes if they in turn received more comprehensive health insurance.

A major limitation to comprehensive catastrophic legislation is the shortsighted approach to financing. Some Members of Congress have expressed opposition to any proposal which is not "generationally neutral." They apparently mean that older Americans alone should share in the cost of expanding Medicare to provide additional services and that it is "unfair" for the working population to participate in the financing. Most proposals impose additional premiums or taxes only on seniors to finance new Medicare coverage. This financing limitation ignores the fact that the problem of catastrophic health care costs for seniors is not generationally neutral.

Generations are interrelated and families do take care of their dependent relatives. Consequently, the pleasure and the burden of caring for individuals at the end of the life span is one that we all share. Family members help each other financially, physically and emotionally. The whole family, young as well as old, has a vested interest in knowing that fathers,

mothers, grandfathers and grandmothers are being well cared for in their old age. It makes more sense to share the financial responsibility through a catastrophic insurance program than through the inefficient and dehumanizing method of bankruptcy and welfare.

By the time of retirement, individuals no longer have the resources to be able to finance all their health care. The financing of Medicare must begin while working. This is the overall principle for current Medicare financing. A young worker with a family, try as he might, will find it difficult to save for his health care protection when retired. And to expect seniors to pay for the full cost of health care will not solve the problem of catastrophic illness, but will continue to foster the problem.

Most senior organizations and some Members of Congress refuse to step forward and lead on the issue of financing. Representative Pepper is not afraid and neither is the National Committee. We endorse the financing proposals in Representative Pepper's bill to eliminate the wage base for Medicare contributions, to transfer some Medicaid resources to Medicare and to add additional contributions from beneficiaries. The National Committee also believes that it is necessary to control open-ended costs through health care delivery reform. Rep. Pepper has proposed a capitation approach. Considering the Administration's interest in capitation, it is perhaps surprising that the President did not adopt Rep. Pepper's approach to providing catastrophic care.

According to a preliminary Congressional Budget Office estimate, the cost of Rep. Pepper's bill would be about \$65 billion a year. The National Committee proposes that seniors pay for approximately half of the cost of a comprehensive Medicare catastrophic package through premiums, deductibles and copayments. Seniors should finance the majority of their share through a premium.

Rather than deducting a flat amount from a Social Security benefit, however, the National Committee recommends a premium that is a percentage of the Social Security benefit. This would insure that all pay a fair share, but not more than they can afford. This financing mechanism is similar in principle to the payroll tax which is a percentage of earnings. If next year's \$22.30 monthly premium was replaced by a premium equal to 15 percent of the Social Security benefit of Medicare eligible individuals, Medicare revenues would increase by over \$20 billion. The average retired worker would pay about \$73 a month (15 percent of \$488), a little more than three times next year's projected premium.

Senior citizens currently pay about \$40 billion a year out-of-pocket for Medicare deductibles and copayments and uncovered health care expenses. The National Committee recommends that Medicare cover all health care expenses and that Congress develop a deductible and copayment package that would reduce out-of-pocket liabilities by one-third to \$10 to \$15 billion a year. With a slightly higher premium, deductibles and copayments could be even less. Deductibles and copayments should be spread over hospital, doctor, nursing home, community-based care and prescription drug costs with an overall ceiling on out-of-pocket costs. Under this financing package, deductibles and copayments would average about \$333 a year. Private insurers would probably be anxious to capture a \$10 to \$15 billion market and would consequently provide insurance packages to cover these deductibles and copayments.

Even assuming a 10 percent saving from health care delivery reform, the financing package does not come together without additional contributions from the whole population. The National Committee supports raising the Medicare payroll tax rate. Raising the tax rate from 1.45 percent to 1.6 percent would raise approximately \$6 billion a year. Eliminating the wage base for Medicare payroll taxes, as Representative Pepper proposes, would raise an additional \$7 billion a year. The National Committee is not opposed to increases in Medicare payroll tax revenues. However, we would also recommend the development of additional financing sources for Medicare that are more progressive and less a disincentive to employment. One suggestion is earmarking income tax revenues for Medicare. A one percent earmarked tax on all taxable income, for example, would raise about \$19 billion a year. To the extent that seniors worked or had taxable income, they would also contribute through the payroll tax and earmarked income tax.

SUMMARY

Of all the legislation introduced to date, the National Committee believes that the best starting point for developing a Medicare catastrophic health insurance plan is the legislation introduced by Representative Claude Pepper, H.R. 65. His legislation offers the most comprehensive coverage. We clearly need to assure senior citizens access to a full range of health care services, including long-term care in a nursing home and prescription drugs. The financing of a Medicare catastrophic health insurance plan will undoubtedly be controversial. At the same time, financing is at the heart of the debate. Without additional financing, comprehensive Medicare catastrophic coverage will remain a fantasy. The National Committee hopes its financing proposals can be a catalyst for further debate and action on an agenda of vital importance for all Americans. It is time that we meet the challenge head on.

Before concluding, I would like to acknowledge the legislative contribution of other Members of Congress, who have made worthwhile proposals to expand Medicare or to ameliorate strict limitations on Medicaid eligibility for nursing home care. The details of some of these proposals should be incorporated into more comprehensive legislation. If action is not taken this year on a more comprehensive proposal, we would expect Congress to act on at least some of the proposals to:

- * clarify eligibility requirements for Medicare home health care
- * expand eligibility for community-based care under Medicare
- * cover prescription drugs under Medicare
- * prevent spousal impoverishment
- * eliminate the requirement for 3-day prior hospitalization before coverage of skilled nursing care
- * increase Medicaid nursing home personal allowance from \$25 to \$35
- * cover adult day care under Medicare
- * cover preventive examinations

This country spends 11 percent of its gross national product on medical care -- more than any other industrialized nation. Yet in comparison with other industrialized nations, we fall sadly short of providing comprehensive health care for our citizens. Because of the limitations of our health care financing, many seniors live with the constant threat of bankruptcy in the face of serious or long-term disability. Let this be the Congress which has the courage and the vision to provide affordable and adequate health care coverage to older Americans faced with a catastrophic illness. To do so would banish the fear of financial hardship from the lives of countless Americans.

THANK YOU.

Statement of

Gerald W. Bush, Ph.D.

President

National Head Injury Foundation

and

Director, Employer-Provided Benefits Program

Heller Graduate School, Brandeis University

before

The Private/Public Sector Advisory Committee

on Catastrophic Illness

August 12, 1986

"The aggregate present value of William's future medical and rehabilitation expenses, including the hospital reserve fund and surgical treatment of the myositis, is from \$2,918,199 to \$3,209,378."
 ("Private economic report," for William X, 1983)

Thus concluded the economic report on a single head injury victim. The report also said "William has received aggressive rehabilitation treatment for 27 months. Although he still has severe cognitive and physical impairments he has responded well to the therapy regime. His progress to date has been extraordinary. There are no indications that his recovery will not continue but the pace, extent and duration of future progress cannot be precisely determined. There is a consensus among attending physicians that William will never be independent or employable."

William was 19 years of age at the time of his auto accident. He has had coma stimulation and rehabilitation for four years at an average cost of

\$127,750 a year. He is one of some 70,000 persons severely head injured each year who require long term rehabilitation, in some cases costing as much as one million dollars per case.

Families of the head injury survivors are painfully aware of the need for catastrophic assistance. We know the stress, pain, suffering, dislocation and huge expense that follows that first tragic phone call. That call that always begins: "Mr. Bush: Or Mrs. Whoever? Your son....your daughteror wife or husband has been in a terrible accident." Six years and one month ago my wife, Jean, and I received that call from Houston, Texas. We were vacationing in Maine, two of our other sons were in Pittsburgh, Pennsylvania. Our then 18 year old son, Patrick, had been in a very serious oil rig accident and was being flown to Herman Hospital. He was not supposed to be alive when we arrived. Today he continues to receive care and rehabilitation near our home in Massachusetts. He continues to make progress. He will never be the old Patrick but he is still improving.

We are extremely fortunate. Worker's Compensation and other insurance plus a legal settlement and personal funds have made it possible for us to spend nearly \$800,000 to date on acute care, coma stimulation, and rehabilitation for our son.

But Patrick Bush and, if I might, the James Brady's of this world, are the exception; the all too rare exception. Only one head injured person in twenty receives any rehabilitation today. Nineteen in twenty simply do not have funding.

The Committee on Trauma Research, Commission on Life Sciences, National Research Council and the Institute of Medicine report, Injury in America, states that head injury accounts for 500,000 hospitalizations each year. There are some 70,000 severe cases each year and some two thousand persons are left living in a persistent vegetative state each year. This is not an epidemic it is an unbridled cataclysm of monstrous human and financial import. When these seventy thousand persons are added to the annual twenty thousand spinal cord injuries, the thousands of stroke victims and the long term mentally ill you begin to define long term non-terminal catastrophic. But it must be also defined in realistic terms: long term rehabilitation and social services.

To complete the picture of head injury you should know that head injury has taken more American lives than all of America's wars since the founding of the Republic. It is the number one killer of persons under the age of 44 and kills more Americans under the age of 34 than all other diseases combined.

You should know that the incidence of head injury among our children is staggering. It is estimated that, yearly, 1 million children sustain head injuries. Of the one million children about 165,000 will be hospitalized.

Of these 165,000, approximately 1 in 10, or 16 to 17,000 children a year will have moderate to severe brain damage. In addition, many children without obvious disability---so-called "minor" head injuries---may show up on the classroom as learning disabled. In a recent survey of 1,500 special education students in Vermont, over 20 percent had a

history of traumatic head injuries severe enough to have required hospitalization; of those listed as "emotionally disturbed," 40 percent had a history of head trauma. None of these children were listed as traumatically brain injured and none were receiving appropriate rehabilitation for traumatic brain injury because no one will pay.

There simply is no insurance available to cover the acute care and rehabilitation of those who suffer traumatic brain injury unless you are hurt on-the-job in a good Workers Compensation state.

The vast majority of traumatic brain injuries, however, are the result of automobile crashes. Some estimate as high as 50% of the 70,00 severe cases. Therefore, the insurance programs of worker's compensation and other structured programs are not available. Few employers - private, public and not-for-profit - provide for extended rehabilitation.

In another case where a seventeen year old male was severely head injured it has been estimated that over the next 50 years, a not unreasonable life expectancy, someone will be required on a cash basis to expend \$50,242,820 for care, rehabilitation, and support. Very few, if any, individuals or families can afford this.

In any case, to state the numbers does not answer the parental question I am asked all across this nation: "Gerry, what's going to happen when we die?"

The numbers associated with severe head injury, the need in many cases to finance a lifetime of care, and the need for institutional development are truly worthy of the word "catastrophic". Without funding nothing will happen. Without funding there will never

be an adequate answer to the question: "What happens when we die?"

In addition to the long time required for rehabilitation, another reason so few of the head injured are adequately served and that their care is so expensive is that head injury survivors are a relatively new disability. That is, surviving a severe head injury was almost unheard of ten years ago. Today, the odds are better than 50/50 that a severe head injury taken to a trauma one center will survive. We all love and celebrate the story of James Brady, the President's press secretary and the newest NRIIF spokesperson. Jim in all probability would not have survived had he sustained his head injury a decade ago. The same is true for our son, Patrick, and thousands upon thousands of others like him. Governments, employers, insurance companies and individuals have spent billions on acute care in almost total disregard of the "downstream" implications of those expenditures.

Furthermore, it is now abundantly clear that persons can show remarkable recovery over long periods of sustained rehabilitation measured in years rather than days and months. There is no question that the average number of days in rehabilitation to which many before me have testified reflects the absence of adequate funding more than the need for and efficacy of additional rehabilitation. There is no debate about the fact that the single number one reason for persons leaving rehabilitation is the termination of their funding source and the family's inability to sustain the huge cost.

Thus the need for catastrophic insurance to cover this new disability, as well as those who suffer from other catastrophic illnesses and injuries, and to sustain a program which will produce the maximum amount of rehabilitation. Again, referring to an extrapolation from the report Injury in America: Only one in twenty head injured survivors have access to or receive any rehabilitative services. The major contributing reason for this is lack of funding.

The National Head Injury Foundation commends you for your willingness to take upon yourselves the charge to look at this incredibly complex issue.

There will have to be a concerted effort on your part to pierce the rhetoric and the reality of the insurance and reinsurance industry. Perhaps your report can serve as a major contribution to the education of insurance companies and employers - public, private and not-for-profit - so that they can begin to understand exactly what is and what is not covered in the medical policies they make available to their employees. Remember the \$500,000 and \$1,000,000 individual maximum limits were established in the 1950s and have not been inflated since. Today it is easy to spend "to the limit".

It is nearly unconscionable that the vast majority of employer paid insurance does not cover rehabilitation. This is absolutely the case for the vast majority of HMO contracts. In this regard I recommend to you a careful rereading of the testimony of Dr. Steven Feinberg before this advisory committee. There is no shock on earth equal to that of a family facing charges upwards of one hundred thousand dollars for acute care and an equal amount each year for rehabilitation when they discover that their employer

provided insurance does not cover such services. There are stories upon stories upon stories in the media and even more among the head injured of such events and I am sure you have heard long testimony on this subject.

However, as we review catastrophic let us not forget the family that lived in the suburbs of the capitol city of this reputedly great and powerful nation. When the jury found there was no liability and thus no funding the family was destitute. The mother of that head injured son returned home from court and took her son's life. She then took her own life.

There can be no question that the vast majority of health coverage is paid for by employers with or without employees sharing in those costs. It strikes us at the National Head Injury Foundation that our advocacy efforts and yours, should be to create a system that would be distinguished at least by the following characteristics:

- 1) Any proposed system should be in addition to and not in lieu of current health benefits.
- 2) The system should reflect the complexity of the "downstream", post acute care setting. That is, coverage should provide for a wide variety of in-home, outpatient and residential rehabilitation, social services and skilled nursing care.
- 3) There should be a cognizance of the fact that a family should not need to pauper itself in order to receive assistance from a catastrophic fund.
- 4) The system should reflect the current pluralism of private, public, employer, Government and

individual contributions to the pooled of that head injured son returned home from court and took her son's life. She then took her own life.

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- 3) There should be a cognizance of the fact that a family should not need to pauper itself in order to receive assistance from a catastrophic fund.
- 4) The system should reflect the current pluralism of private, public, employer, Government and individual contributions to the pooled risk-sharing.
- 5) Your view should include the poor, the full and part-time working population, the unemployed, the low and moderate paid, and current public program beneficiaries and it should be a complement to an extended employer provided insurance system.

- 6) Your view should include a variety of tax incentives such as medical IRAs or medical 401(k)s so that individuals, employers and governments would participate in the development of the pool.
- 7) The best plan would include the largest number of participants in the risk-sharing.

There is no question that statistically those requiring catastrophic coverage are, as a percent of the total population, very small. There is no question that for that small percentage of the total population the effect is totally devastating financially and this only adds to the phenomenal psychological burden of grief, anger and hopelessness. The single most important element for this committee is to entertain the concept of a just, equitable and widely spread risk sharing.

Thank you.

DEPARTMENT OF HEALTH & HUMAN SERVICESPrivate/Public Sector Advisory Committee on Catastrophic Illness

August 12, 1986

Testimony of

Robert J. Demichelis &

Alice M. Demichelis

Reston, Virginia

Department of Health & Human Services

Private/Public Sector Advisory Committee on Catastrophic Illness

August 12, 1986

My name is Robert Demichelis and I am accompanied by my wife, Alice, who is a full-time unpaid volunteer for NHIF, talking to members of Congress and any representatives of government agencies who will listen. I am an attorney and have been employed in the life and health insurance business for over 25 years. We are residents of Reston, Virginia and are appearing here today in the capacity of parents of a head-injured child. You have heard previous testimony from Dr. Gerald Bush of the National Head Injury Foundation who has described the needs for catastrophic care due to all types of head injury. We would like to personalize the needs for catastrophic care for the "under 65" population.

Our son, Robert, who is now age 30, was injured in an automobile accident in February of 1980, over six and a half years ago. Prior to Robert's accident, he had completed college where he graduated with honors in accounting and finance and also was honored as a member of the Midwest All

American Soccer Team for his junior and senior years. Robert sought employment in the Chicago area, where our family lived until moving here 10 years ago. He was hired by one of the "big eight" accounting firms. They had a good employee benefits program, but as I will show later, not good enough. He passed all four parts of the CPA exam at his first sitting. During his first year of work as a CPA, his performance was recognized by his employer, and he received a promotion, as well as salary increases. He continued playing soccer on an amateur basis and was invited to try out for professional teams. He was in excellent physical condition, when in February, of 1980, he had an automobile accident.

Robert and his roommate were returning from a basketball game at Northern Illinois University, where they had gone to school. Robert was driving his recently purchased automobile and was involved in a single car accident on the interstate highway on his return to Chicago. The left front of the automobile was demolished as a result of the collision with a concrete abutment. Robert's roommate was fortunate in receiving only a minor injury to his mouth and was released from the hospital after a short period of observation. Robert, however, was not so fortunate. Robert spent the next three weeks in a coma at Good Samaritan Hospital in Downers Grove, Illinois. He received excellent medical attention, the brain swelling was contained although his coma persisted over that three week period. During the next six weeks, he had to learn how to walk and talk again, even though he suffered no paralysis or other physical disability. After two months at Good Samaritan Hospital, we transferred Robert to George Washington University Hospital, Rehabilitation Ward by air medical evacuation, to be closer to home. I must point out that Robert's medical insurance did not pay for this transfer by airplane. After three weeks at George Washington University Hospital where he received physical therapy, speech therapy and other standard therapies for automobile accident victims,

Robert was released home to our residence in Reston, Virginia. Most (80%) of Robert's medical bills were covered by his group health insurance through his employer, except of course his air med-vac from Chicago to Washington, DC. During Robert's hospitalization in Chicago and Washington, DC, he was treated by neurologists who identified his brain damage as a closed-head injury, with lower brain stem damage and frontal lobe damage. He was fortunate, as I stated before, that he had no other physical injury except a broken collar bone. Robert's therapies at George Washington Hospital did nothing to address the personality and cognitive disfunctions that resulted from his brain trauma. No recommendations were made for cognitive remediation to address his impaired learning and reasoning processes. He was just discharged home. He was advised to consult a vocational psychologist connected with George Washington University. Although this psychologist had a very fine reputation, we were very much surprised to learn that the psychologist had no experience or training that would help him in dealing with a CPA's occupational responsibilities.

In January of 1981 Robert returned to Chicago, on his own volition, to resume his responsibilities to his employer. His doctors gave no warning of what to expect. We did counsel his employer not to subject Robert to the same type of case load that he had previous to the accident. Over the next six months it became apparent to Robert's employer that he was having difficulties in dealing with clients and fulfilling his responsibilities, although Robert would never admit it. He received psychological counseling after his return to work but his performance continued to deteriorate, not only on the job, but also with his two roommates. In August 1981, Robert's employer unilaterally transferred him to their Washington, DC office, placing him on disability. His employer suggested strongly that he return to our house in Reston, Virginia and to resume contact with the medical professionals who had previously treated him. Since that time, over five years ago,

Robert has not been employed in any capacity. In fact he has been medically determined to be "unemployable."

In February 1982, Robert's doctors advised him to enter the Psychiatric Institute of Washington, DC for treatment of his behavioral problems. After two months at the Psychiatric Institute, 100% of the psychiatric benefits (\$25,000) available to him under his employer's medical insurance policy were exhausted. The treatment Robert received at P.I. was totally inadequate and inappropriate to a person suffering a traumatic brain injury. In fact, two weeks after his discharge a catastrophic personality conflict resulted in Robert being committed to the Northern Virginia Mental Health Institute.

In March 1983, Robert's disability income insurance ran out after the two year period due to his inability to perform his own occupation. Robert's employer informed him that his employment was terminated and that he had the option to convert his group medical insurance coverage, but admittedly on a limited basis. He was advised by his employer to apply for Social Security Disability Income benefits and that when social security benefits were awarded that his medical insurance would be reinstated. Alice and I assisted Robert in applying for the social security benefits, over his objections, since Robert's brain injury did not permit him to recognize the full extent of his disability, or the consequences of his failure to apply. In fact, on his application to social security, he stated that the primary cause of his disability was a minor knee injury, not the traumatic brain injury. Robert's application has been denied twice, and the matter is now in the hands of a local law firm. Under an act of Congress last year, his application is currently being re-reviewed. (He was injured six and a half years ago and hasn't been employable in any capacity for over five years; and still no decision by Social Security.) Meanwhile, Robert's medical insurance coverage has been terminated and his mother and I have paid all of his medical expenses. These costs do not reflect the family trauma or

other expenses incurred due to Robert's aberrational behavior and impaired judgment, including several incidents with the law enforcement authorities. Numerous attempts at vocational rehabilitation through the efforts of the Virginia Department of Rehabilitation have been unsuccessful. On one occasion he was dismissed from a "sheltered workshop."

The treatment of traumatic brain injury is a long, elaborate and expensive process, as you have heard from Dr. Bush. I have attached to my testimony today some materials which elaborate on the extensive nature of the catastrophic care required for treatment for the brain injured. The first attachment is an address made on April 18, 1986 by Madeleine Will, Assistant Secretary for Special Education and Rehabilitative Services, Department of Education. The second attachment is from the Virginia Head Injury Task Force Report submitted to Joseph Fisher, Secretary of Human Resources, State of Virginia in November, 1985. A third attachment is a California Statute (Ch. 1658) enacted in 1984 which is one example of state efforts to provide services to brain-injured adults.

Current insurance policies lack the comprehensive coverage essential to provide for the treatment of brain trauma. As I mentioned previously, Robert was involved in a single car accident, therefore there was no liability insurance involved to help offset any medical expenses. Robert's accident took place in Illinois, which does not have no-fault auto insurance. If he had been fortunate to have been involved in an accident in the state of Michigan, Robert's rehabilitation expenses would have been covered by no-fault auto insurance. (See attached articles from Consumer Reports and the Washington Monthly.) Robert's accident did not occur in an employment capacity therefore he was not covered under workers' compensation insurance. If he had been involved in a work-related accident, most of the rehabilitation expenses

would have been mandated. If Robert had converted his group insurance coverage to individual coverage following his termination, the benefits so limited that even his employer would not recommend conversion. Of course, his disability income insurance does not cover the costs of rehabilitation. I am attaching to this statement copies of two reports submitted to the Insurance Task Force of the National Head Injury Foundation in January, 1986, which address the "Gaps and Problems in Insurance Coverages." Also attached is a statement on "Catastrophic Health Insurance Coverage, The Dilemma of Economic Responsibility" published in 1985.

What we are trying to say by setting out this past history of our son's traumatic injury, is that the issue of catastrophic health care is not an issue that relates solely to the elderly. There are thousands of individuals such as Robert, who are in the prime of their life, between the ages of 20 and 45, who have suffered traumatic brain injury and who have no insurance coverage to turn to for the costs of rehabilitation, or the costs of other medical expenses. Another example of the need for catastrophic care was reported in a series of articles in the Washington Post on June 8-11, 1986. It was the story of Brian Rife. His parents negotiation for rehabilitation coverage through an H.M.O. emphasizes the need for adoption of a national policy. Following publication of this series, Congressman Fortney (Pete) Stark, in a letter to the editor of the Post on June 23, 1986, stated the need very well. I quote:

"When an individual is injured, society should provide the support necessary to maximize that individuals return of function."

We believe that statement should be foremost in the mind of the Committee.

The issues of catastrophic care of a head injury are extremely complex. Our son is an adult and legally independent. My wife and I have no authority to make decisions

on his behalf. We have attempted in the Virginia courts to obtain a limited guardianship over our son for the purpose of sending him to a rehabilitation treatment center for head-injured persons. We told the judge that we would remortgage our house (our major asset) to pay for the treatment, since Medicaid would not pay. Our efforts were unsuccessful because of the limits of existing Virginia statutes. During the past four years I have paid for Robert's out-patient therapy with neuro-psychologists and speech therapists who deal specifically with head-injured persons. My out-of-pocket costs have been close to \$25,000. These professionals have exhausted their abilities to deal with Robert as an out-patient. Their recommendation is for Robert to enter a residential treatment program for the head injured. They believe that a proper program will succeed in Robert's return as a viable member of society; probably not at a CPA, but certainly not as a welfare recipient. The medical profession had the ability to save Robert's life; bring him out of a coma; teach him to walk and talk. These expenses were covered by insurance. But that is as far as the insurance would go. Neither his employer or the insurance company attempted to bend the rules to pay for the expense of essential rehabilitative care. The simple solution was termination of employment; ship him home to his parents; and put him on welfare. Without us or a place to live, Robert would be roaming the streets with the other homeless population, until he would eventually end up at some mental institution which would undoubtedly fail to recognize that he was a helpless victim of traumatic brain injury.

Our involvement with the National Head Injury Foundation and the Virginia Head Injury Foundation has introduced us to hundreds of people who have had similar experiences that could be repeated to this Committee. We respectfully request that the Department of H.H.S. address the issue of catastrophic

health care as it pertains to individuals like our son Robert who in the prime of their lives, have no place to turn. Medicaid and Medicare will not provide for his treatment; conversion of his employer's group health insurance will not provide for his treatment; disability income payments will not provide for his treatment. Worst of all, Robert's brain injury will not allow him to admit that he needs treatment. We present you with an example of need and plea for your compassionate consideration of alternatives for solving this complex health care issue. Thank you very much.

Attachments:

- ~~1. Remarks of Madeleine Will - April 18, 1986~~
2. Virginia Head Injury Task Force Report - November, 1985
- ~~3. California Ch. 1568, Statutes of 1984~~
4. ~~Whatever Happened to No-Fault?~~
Consumer Reports - September, 1984
5. ~~Whatever Happened to No-Fault?~~
The Washington Monthly - April, 1986
6. National Head Injury Foundation
Insurance Task Force Report - 1986
7. Catastrophic Health Insurance Coverage
The Dilemma of Economic Responsibility

[The above-listed attachments are being retained in committee files.]



STATE OF NEW JERSEY

DEPARTMENT OF COMMUNITY AFFAIRS

DIVISION ON AGING

363 WEST STATE STREET

CN 807

TRENTON, N. J. 08625-0807

LEONARD S. COLEMAN, JR.
COMMISSIONER

March 30, 1987

APR 2 1987

Joseph K. Dowley, Chief Counsel
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Dowley,

Thank you for the opportunity to present our statement to be included in the record of the hearings on the proposal for catastrophic benefits in Medicare.

Without minimizing the value of additional protection, an unlimited hospital stay is not the most critical medical cost facing the elderly population. Data show that less than 1% of persons 65 and over hospitalized in 1984 used any of their lifetime reserve days. On the other hand, current benefits for home care are available only under very limited circumstances, and the current proposals for catastrophic coverage do not address the issue.

We urge that consideration be given to the most needed benefits of long-term care for the chronically ill, both in the home and in institutions.

We in the N.J. Division on Aging are aware that the problem of most concern to older people and their families is the absence of insurance coverage, for all but the very poor, of long-term care for chronic conditions. In our view, this is the real health care catastrophe.

National estimates report that about half of those 65 and older who require assistance in their activities of daily living receive this care from a spouse, a relative or a friend. The other half are in a dilemma. Nursing home care cost averaged \$23,000 in 1985 in New Jersey. Medicare will pay for 20 days, but only under strictly defined conditions. In any case, most people prefer home care over institutional care. The services that are needed to help people remain at home are often non-medical supportive services. However, Medicare reimburses for home care only when medically necessary, and then only for 2 or 3 hours, 2 days per week - hardly adequate to prevent institutionalization.



NEW JERSEY IS AN EQUAL OPPORTUNITY EMPLOYER

-2-

Private initiatives in long-term care insurance are developing - slowly - but it is unlikely that the industry will ever be responsive to those in the median-income range.

If we compare the financing of acute care with that of long-term care, we see that Medicare pays 80% of the acute hospital and physician costs, while less than 2% of nursing home costs are covered. Private Insurance covers less than 1% of nursing home care, while Medicaid pays about 43%, with patients and their families meeting about 50% of the costs. (These figures are from data collected by proprietary health care facilities in New Jersey, and reported in 1986.)

Costs of long-term care lead to the impoverishment of many elderly, as has been well-reported. About half the nursing home residents being supported by Medicaid were not poor at the time they were admitted.

Currently, Medicare pays for virtually no home care for the chronically ill. If nursing home and non-institutional care were covered under Medicare, the costs of this protection would be distributed over a large insured population and services for both acute and chronic illness could be integrated, thus providing both better care and administrative efficiency.

Although there is a growing interest on the part of the insurance industry to provide coverage for long-term care costs, both the availability and the coverage is still very limited. Premiums are related to age, so that annual cost for a 75 year old is likely to be 2 to 3 times that of a 65 year old.

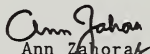
This issue of private-sector insurance is one of the areas addressed in the report of the Harvard Medicare Project, "Medicare: Coming of Age--A Proposal for Reform," which concludes that the federal government has to assume a significant responsibility in assuring that the elderly have adequate protection against the costs of illness. The Report cites the history of Medicare's development, and states that the Medicare program was created because the private sector did not do the job.

We have an analogous situation today where chronic care coverage is concerned.

Even for those elderly who can afford to purchase one of the insurance products now available, the conditions of coverage may be viewed as inadequate. Most so-called nursing home policies provide coverage only after a prior hospitalization, and for medically necessary care. This would probably eliminate benefits, for example, for New Jersey's estimated 190,000 victims of Alzheimer's Disease and Related Disorders. In addition, underwriting standards make it difficult for the old-old to qualify.

We hope that in the examination of catastrophic illness coverage, the critical issue of long-term care costs can be included, the need for long-term care benefits can be acknowledged and a program for meeting this need provided, so that a system can be in place before we reach the next crisis - - the aging of the baby boom.

Yours truly,


Ann Zahorac
Director

STATEMENT OF GERALD S. PARKER TO THE
SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS

10 March, 1987

My name is Gerald S. Parker. I reside at 11 Shore Acre Drive, Old Greenwich, Connecticut 06870. I am a retired vice-president of The Guardian Life Insurance Company of America, a major life insurance company domiciled in the State of New York. I put The Guardian into the business of Health Insurance for the first time in 1951 - 1952, and I ran the operation for 30 years. In addition, I was a member of the Commission on the Evaluation of Pain, appointed by the Secretary of Health and Human Services to study the question of disability due primarily to pain. (The Commission finished its work asnd reported near the end of 1986). I am testifying on my own behalf as a concerned citizen, representing no one but myself.

In 1966 when Medicare was first enacted, I personally designed a Medicare supplement policy which was introduced for sale on 1 July, 1966, the same date Medicare went into effect. This policy did not cover the initial Part A and Part B deductibles, but it did cover all Medicare co-payments plus a very considerable amount of private duty nursing.

In later years, the policy was modified to increase the payments as the co-payments increased and to keep the deductibles at levels that permitted reasonable premiums by not requiring the processing of claims on the majority of policyholders every year, but concentrating instead on the large and financially crippling claims of our seriously ill policyholders.

New sales were discontinued after the Baucus Amendment in 1980 caused the adoption by most states of foolish and often unique coverage requirements, most of which required full coverage of the initial deductibles. We believed that it was uneconomic and contrary to the best interests of policyholders to insure those deductibles on an individual basis without employer tax-deductible contributions. And the unique requirements in many states was forcing the development of a profusion of policies instead of one we could sell everywhere.

I urge the Subcommittee not to adopt proposed legislation to add catastrophic expense coverage to Medicare as urged by the Administration. I urge this for two reasons, as follows:

1. As proposed, this coverage will be extremely expensive. The monthly premiums proposed by the Administration are far too low. I remind the Subcommittee of the initial cost projections of Medicare itself in 1966 and the subsequent explosion of costs. Nothing in subsequent medical treatment techniques promises anything less in the way of cost escalation. Particularly in the case of the aged patients, extraordinary measures to prolong life uselessly beyond any hope of recovery can cost tens of thousands of dollars per patient very quickly. Such measures would be universally pushed by medical personnel and hospitals if they were covered by Medicare without limit, especially in today's litigious climate.

Add the cost of catastrophe coverage as the already large elderly population becomes an even larger proportion of the population, and you will have once more mortgaged the financial future of our grand children for the benefit of us oldsters.

2. Private insurance can provide such coverage about as economically as the Government can. And private insurance would ensure that participants would have a choice of benefit limits and prices to fit their needs. The administrative costs for true catastrophic coverage on a private insurance basis need not be significantly

higher than on a government plan as this would be true insurance - with low incidence rates and high severity when it is needed.

The frequently raised complaints about the cost of private Medicare Supplement insurance arise, because private insurers are required to cover the initial Medicare deductibles. Any time you provide insurance benefits for expenses that are incurred virtually every year by every person insured, you must incur extremely high administrative costs.

Physicians have not been able to raise their fees to Medicare patients for the last two years. In my town, the office visit fee is now about \$35.00 for an internist. So the third visit gets me past the Medicare Part B deductible. How many Medicare beneficiaries do you think go a year without seeing a doctor three times? Very few, I assure you. In most cases, the initial hospital deductible is used up in the first day in hospital.

Repeal the Baucus Amendment and pressure the states to similarly amend their requirements, and I am sure you will find the insurance industry ready and willing to provide excellent catastrophe Medicare supplement coverage at reasonable prices. Were I still managing such a business, I'd be working on the policy when the bill was in committee, and I'd be ready to sell very shortly after it had been agreed to in conference. Furthermore, health requirements for applicants would not need to be better than average for their ages.

I thank the Subcommittee for its attention.

27 Mar, 1987

STATEMENT OF GERALD S. PARKER, 11 SHORE ACRE DRIVE
OLD GREENWICH, CT 06870

TO: THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON WAYS AND
MEANS IN CONNECTION WITH THE HEARING
OF 30 MARCH, 1987 ON EXPANSION OF MEDICARE TO
INCLUDE CATASTROPHIC COVERAGE

SUBJECT: CLARIFICATION OF STATEMENT FILED BY
GERALD S. PARKER IN CONNECTION WITH THE HEARING ON 10 MARCH,
1987 FOR CONSIDERATION IN CONNECTION
WITH THE HEARING OF 30 MARCH, 1987.

In re-reading my statement made for the hearing of 10 March, 1987, it appears to me that the comments concerning the effect of the Baucus Amendment and the recommendation may be misleading.

I should like to make it clear that the Baucus Amendment did not directly lead to the requirements for covering the initial deductibles and thus making much coverage too expensive for many Medicare recipients; rather, it influenced the state legislatures to enact these requirements, each falling over itself to enact more stringent requirements than its neighbor.

Thus, it is not that the Baucus Amendments needs to be repealed, but that it needs to be amended, or other legislation introduced, to influence state legislatures to undo their ill considered legislation that goes far beyond the requirements of Baucus and becomes counter-productive.

March 30, 1987

Edward R. Roybal
 EDWARD R. ROYBAL
 Chairman, House Select Committee on Aging

**TESTIMONY ON CATASTROPHIC HEALTH CARE LEGISLATION
 TO THE HEALTH SUBCOMMITTEE OF THE COMMITTEE ON WAYS AND MEANS
 Washington, D.C.**

Mr. Stark and Mr. Gradison. I would like to take this opportunity to express my deep appreciation to both of you for the leadership you have shown with respect to the catastrophic health care issue and to the many other critical Medicare issues. Both of you are to be commended for your unwavering commitment to protecting Medicare beneficiaries and for your special concern for lower income beneficiaries.

As you well know, I have frequently stated my fear that this year's catastrophic health care bill will fail to fill Medicare and Medicaid's real gaps or to solve the full problem of the 37 million uninsured and the 200 million underinsured. However, I also understand the desire to pass some type of limited and less costly catastrophic health care legislation quickly.

In response to those who have asked for a more limited catastrophic health package than my more comprehensive "USHealth" Act (H.R. 200), I am about to introduce the following catastrophic health initiative (CHI) -- **the Medicare and Medicaid Catastrophic Acute and Transitional Care Act -- which includes a "Federal Medigap Insurance (FMI)" plan and increased Medicaid protection.** (See attachment.) Though this type of catastrophic proposal is a first step toward catastrophic protection and better protects the children, elderly and disabled, we must be mindful of its limitations. That is, it does not fill most of the real gaps in Medicare, it does not solve the long term care problem and it does not protect most uninsured.

Given its limitations, you might ask why I am introducing this particular package. Very simply, many members, including myself, expressed their desire to provide more protection than the package offered by the Administration. However, these members also indicated that they felt they could not go as far this year as the more comprehensive proposals offered by myself and others. I believe that this package, at a price tag of about \$15 billion, fills that void.

What improvements does this catastrophic health initiative (CHI) make on the Administration proposal? They include the following:

MEDICARE: (Federal Medigap Insurance (FMI))

- * Lowers the catastrophic cost limit from \$2000 down to \$500 and better protects lower and middle income beneficiaries.
- * Adds a catastrophic prescription drug benefit with cost controls.
- * Strengthens Medicare's transitional care package by removing the three day prior-hospitalization prerequisite to nursing home care, relaxing the definition of skilled nursing home care and home health care and thus increasing access, and better defining home health intermittent and homebound requirements.
- * Adds a limited and flexible respite care benefit.
- * Uses a fairer financing mechanism that is less regressive than a straight premium and that avoids taxing the value of current Medicare benefits.

MEDICAID:

- * Adds coverage for more near poor women and infants.
- * Adds coverage for more poor children.
- * Improves spousal income and asset protection and raises personal needs allowance for nursing home residents.
- * Adds first dollar coverage for elderly and disabled's Medicare cost-sharing.

I believe that this catastrophic health initiative (CHI) provides important, limited catastrophic protection for Medicare and Medicaid beneficiaries without having to tax existing Medicare benefits or increase the deficit. This package incorporates the strengths of the Administration and Stark/Gradison proposals while providing better protection, especially for lower income elderly and nonelderly. Its total cost of about \$15 billion is not only affordable, but most of the costs for the new Federal Medigap Insurance will be paid by the elderly and by disabled Medicare beneficiaries themselves.

March 30, 1987

EDWARD R. ROYBAL
Chairman, House Select Committee on Aging**ROYBAL CATASTROPHIC HEALTH INITIATIVE (CHI), THE "MEDICARE AND
MEDICAID CATASTROPHIC ACUTE AND TRANSITIONAL CARE ACT" — H.R. ____****MEDICARE PROVISIONS (Federal Medigap Insurance):**

- 1) **A \$500 catastrophic limit is placed on beneficiary out-of-pocket costs** resulting from any Medicare Part A and B coinsurance/deductibles (including prescription drugs, transitional care, and respite care) and is indexed to increases in the Medicare Part A and Part B per capita costs. (Start-up date: January 1, 1989.)
- 2) **Prescription drugs are added as a benefit** subject to a \$300 deductible and a coinsurance of \$2 per prescription and subject to the above catastrophic limit. The DHHS Secretary shall design the prescription drug benefit program so that drugs are purchased from participating pharmacies only and prescription drug prices are prospectively set by Medicare. (Start-up date: January 1, 1990.)
- 3) The following changes are made in hospital coinsurance and deductible: (Start-up date: January 1, 1989.)
 - a. There would **no longer be any hospital coinsurance except for one deductible per calendar year.**
 - b. The hospital deductible is indexed to the percentage increase in the Social Security COLA.
- 4) Transitional care is strengthened by the following changes in nursing home and home health care:
 - a. The skilled nursing (extended care) home benefit is redefined as follows:
 - The three day prior-hospitalization requirement for skilled nursing home care is dropped. (Start-up date: January 1, 1989.)
 - Skilled nursing facility care is increased to cover up to 150 days. (Start-up date: January 1, 1989.)
 - Nursing home coinsurance is reduced to 1/5th of nursing home costs (based on the national average per diem Medicare reasonable cost for SNF services) and is applied only to the first seven days. (Start-up date: January 1, 1989.)
 - The definition of "skilled nursing home care" is refined to allow better access to skilled nursing care by: 1) defining, as eligible, skilled nursing services required on a regular, but not necessarily daily basis, as certified by a physician; 2) making explicit that skilled nursing services include physical therapy and rehabilitative services needed on a regular basis to preserve or restore functional capabilities or to prevent further deterioration, including the training of patients and caregivers in rehabilitative techniques; 3) making explicit that, in determining eligibility for skilled nursing services, "practical matter" considerations be included regarding a) the availability of home support and b) the lack of Medicare coverage for home health services that are certified by a physician as being medically necessary. (Start-up date: January 1, 1990.)

b. **The home health benefit is redefined** as follows:

- Home health care is defined as "intermittent care" including 1) up to one or more home health visits per day up to 7 days a week for up to 90 days a year and thereafter, under exceptional circumstances, as certified by a physician, and 2) home health visits at a frequency of less than 7 days per week for an unlimited period of time as certified by a physician. (Start-up date: January 1, 1989.)
- "Homebound" is clarified as a situation where there is a normal inability to leave home and, consequently, to leave home would require a considerable and taxing effort. Occasional absences from the home are permitted for medical or non-medical purposes. (Start-up date: January 1, 1989.)
- The definition of home health care is refined to include: 1) on a physician's prescription, such personal support services as needed on a short term basis to offset problems of limited home support that would otherwise preclude beneficiaries from receiving home health services for which they are eligible; 2) on physician prescription, such short term rehabilitative services as needed on a regular basis to preserve or restore functional capabilities or to prevent further deterioration, including the training of patients and caregivers in rehabilitative techniques. (Start-up date: January 1, 1990.)

c. **Plans of care are required**, as condition of participation under Medicare, for all patients needing transitional care and respite services and are required of all providers (including primary care physicians, hospitals, nursing homes, HMOs, home health agencies, hospices). The plan of care is to include an assessment of patient needs, the services to be provided and the provisions for discharge. The plan of care is to be prepared, implemented and periodically review and updated through consultation among appropriate providers including physicians, nurses and social workers, and are to be signed by a physician. PROs are to oversee quality and effectiveness of plans of care. (Start-up date: January 1, 1989.)

d. **Demonstration projects** are to be carried out on "managed care" approaches to providing transitional nursing home, home health and respite care services including 1) approaches similar to the Medicaid Home and Community Based Services Waiver Program, and 2) the full range of nursing home, home health, and respite care services as provided by this Act. (Start-up date: July 1, 1988.)

5. **The DHHS Secretary is required to develop and implement respite care as a new benefit when prescribed by a physician.** The respite care benefit shall, at the beneficiary's choice, cover up to 10 days of nursing home care per year (based on the national average per diem Medicare reimbursed cost for SNF services) or the equivalent dollar value of hospital-based respite care, adult day health care, or in-home care. A 50% co-insurance is required up to the catastrophic limit. (Start-up date: January 1, 1990.)

6. **The hospice benefit is extended** beyond the current 210 day limit if the patient is recertified as terminally ill. (Start-up date: January 1, 1989.)

7. **Enrollment in the FMI package** is automatic for Medicare beneficiaries enrolled in Medicare Part B.

8. Financing for the FMI package comes from the following sources:

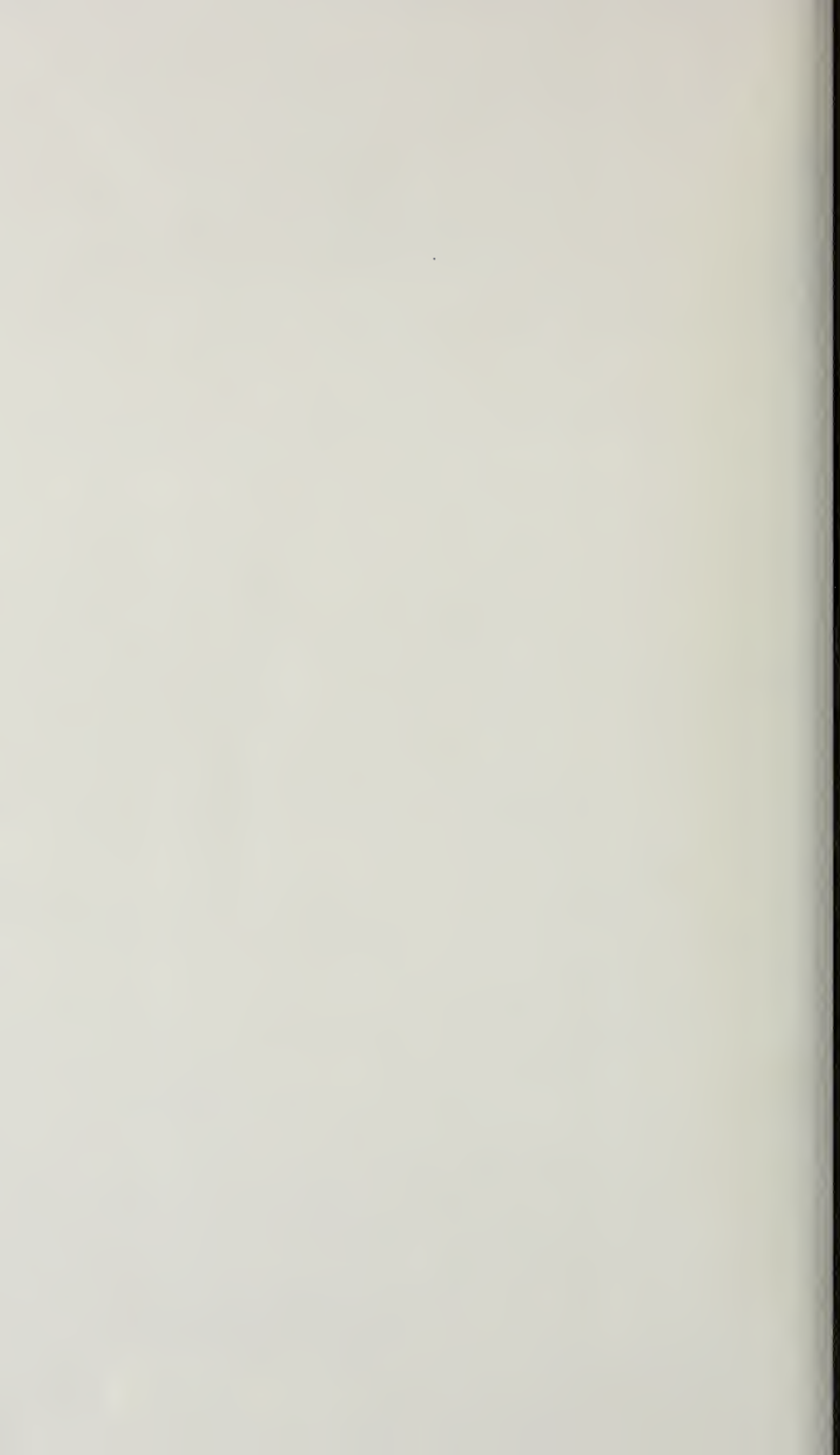
- a. One-half of the revenues from raising the cigarette tax by 16¢ and indexing the tax to the Consumer Price Index. (Start-up date: January 1, 1989.)
- b. An initial FMI premium of \$10 per month which is indexed to increases in the cost of the Social Security COLA. (Start-up date: January 1, 1989.)
- c. The remaining expanded benefit package is financed by the elderly through a special add-on tax on elderly income which is not a tax on the actuarial value of Medicare. This special add-on tax on people age 65 and over is applied as a percentage of taxable income and is set at a level (rounded up to the next highest one-half of one percent) actuarially sufficient to cover the cost of the FMI package less the cigarette tax and premium financing. Initially this special add-on tax is estimated to be about 4% of taxable income. (Start-up date: January 1, 1989.)

MEDICAID PROVISIONS:

1. States are given the option under Medicaid to a) extend coverage for pregnant women and infants up to age one regardless of family composition with incomes up to 185 percent of the Federal poverty level and b) accelerate coverage of children up to age 5 who are under the Federal poverty level. Continued Medicaid coverage is mandated for children who are on Medicaid but go past the age 5 limit. (This proposal was introduced by Representative Waxman as H.R. 1018.)
2. Medicaid coverage is mandated for all children under age 18 (and 18 to 21 year olds in school, jobs, or job training) with family incomes/resources under the state poverty level.
3. States are given the option under Medicaid to cover any child under age 21 with family income below the federal poverty level but over the AFDC level.
4. Medicaid coverage is mandated for all children under age 5 who have family incomes below the federal poverty level.
5. States are required to cover Medicare Part B premiums and cost-sharing on behalf of their elderly and disabled Medicaid recipients.
6. Medicaid institutes a spousal protection plan protecting limited amounts of income and assets when one member of an elderly couple is placed in a nursing home and is covered by Medicaid. (Note: This proposal was introduced by Representative Waxman in H.R. 1711.)
7. The Personal Needs Allowance is raised from \$25 to \$35 per month. Before the additional money is made available, the Secretary is required to take the necessary steps to ensure that the additional funds be used only for the personal use of the patient and not to pay for any nursing home related costs.
8. Financing for the Medicaid package comes from the following sources:
 - a. Federal Medicaid savings resulting from Medicaid's buy-in to the FMI package.
 - b. One-half of the revenues from raising the cigarette tax by 16¢ and indexing the tax to the Consumer Price Index. Funding from the raised and indexed cigarette tax will be used to offset the added Federal costs of this Medicaid package less any Federal savings resulting from the Medicaid buy-in. Any cigarette tax funds not used to fund the Federal costs of this Medicaid package are to be made available to the States for their Medicaid programs.



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